Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 **Physician** A^{M} May 9, 1:05 Patrick Joseph McDonough /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Feb. 22, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 X M 2 □ F 325-26-8859 Illinois 76 Feb. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7533 Tour Drive 21601 United States Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 □ No If Yes, Give Korean Year or Dates: Conflict 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Counseling Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wing permit. Department of Health and Mental Hygien Important: If item 27 is marked other than any Injury or other traumatic event, the Executive Director Development 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patrick Joseph McDonough, Sr. Genevieve Shea 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy Oliver McDonough/Wife 7533 Tour Drive, Easton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 mysluce M01173 23a. Part1. Enter the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia minutes /Medical Due to (or as a consequence of) Examiner Anemia due to Gastrointestinal Bleeding months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Linknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 5 perform 2XINo 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Yes 2 ☐ No 1 Inpatient 2 X ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Hospital or Attending 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the

10+1

Poopak Bakhtiari, M.D. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MAY 1 6 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

63324

9901 Medical Center Drive, Rockville, Maryland

29d. Date signed (Month, Day, Year)

05/09/08

DHMH 17 Rev 1/2001

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ryland		irtmen <i>tificate</i>			/lental H	ygiene Reg. No.	,	
	Physicia		1. Decedent's Name (First, Middle, Last)	s Ni	EGR					2. Date of E		2008	3. Time of Death 2
	/Medic	24	4a. Facility Name (If not institution, give st				4b. City,	Town, or	Location of Death			County of Death	
	Funeral Director		Laurel Regioanl Hospit. 5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age	(In yrs. las	t birthday) Yrs.	Laure If Under Months		If Under 24 Hrs. Hours Min.	8. Date of E (Month, I	Day, Year)	Cou	eorges place (State or Foreign ntry)
	And the second		Usual Residence of Decedent							1.00			
	the Marylan 28a-f show notified at	tor	Maryland Prince Geo		10c. City, T	Fown or Loc ⊛1	cation						10d. Inside City Limits 1 ☐ Yes 2 🌠 No
	h the	irec	10e. Street and Number	1			10f. Zip	Code			10g. Citiz	zen of What Cou	intry?
	th wit 23a c 1st be	al D	7901 Laurel Lakes Cour	t, Apt 217			207	707			USA	4	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:			Vas Deced f Yes, spec		spanic Origin? (Sp n, Mexican, Puerto Specify: Pue	ecify Yes or to Rican, etc.)		14. Race - Ameri Black, White, Specify: Whi	, etc.
21215-0036	iithin 72 ho ne. han "natur e Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) Coilege (1-4or 5-		life. L	kind of wor OO NOT us	rk done a	luring most of worl	king		nd of Business/Ir	ndustry
121	filed within Hygiene. rther than "	ខ	12 17. Father's Name (<i>First, Middle, Last</i>)			Retai	i ! 		18. Mother's Nam	e (First Midd			
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Maryland	should be fand Mental I s marked of umatic eve	ပ္	Rito Negron Rodriguez 19a. Informant's Name/Relationship (Typ	e. Print)		19b. Mailin	a Address	(Street a	and Number or Ru		nber, City o	r Town, State, Zi	ip Code)
Ma	and 2 sealth ar		Jaime Negron- Cousin	,			_		Drive, Co				,
Ē,	is 1 a of Hea item othe		20a. Method of Disposition		20b. Plac	ce of Disponetery, cren	sition (Nar	ne of	i	Date		cation - City or T	own, State
imo	Pages ment of R ant: if ite ury or of		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		opolita				+, 2008	Alexa	andria, Vi	rginia
Baltimore,	permit. Departi Imports any Inj	i i	21. Signature of Funeral Service License	M012	34	F1	leck F	unera	s of Facility I Home, INC oring Rd.,		MD 20	707	
p.			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused e cause on each line	the death.	Do not ente	er the mod	le of dyin	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	SE	2515								Oriset and Death
7	/Medical Examiner		resulting in death)	Due to (or as a				N-1	· - ·				
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W	uted d ansit	Examiner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events	ESRD		,							
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68760,	ficate be executed physician and is the burial-transit	edical	d	THRON	nbo c	YTOP	ENI	A					
O. Box 68	death certi e attending ed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome p 1□Live birth 4□Pregnant at 9□Unknown	2 🗆 Fetal d	eath 3	Ectopic pi				_	23d. Date of deli	very Day Year
P.(that the de led by the a detached	P _y	Part II. Other significant conditions con	tributing to death bu	t not resulti	ing in the ur	nderlying c	ause nive	en in Part I	23e. Di	d tobacco i	use contribute to	the cause of death?
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Division or Vital Records,	The ate hi	Completed by								24a. W au pe 1∐ Ye:	itopsy erformed?	prior to c	topsy findings available completion of cause of 2 No
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2	Physician: r this certificanal director,	2	1 1 1 es 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ospital: 1 Inpatie		R/Outpatien			4 Li Nursing H			6 □Other (Spec	cify)
ion (ling I	ation:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day		8b. Time of Injury	M 2	28c. Injur Worl 1 □	y at <br Yes 2 □ No	28d. Describ	oe how inju	ry occurred	
27. Manner of Death Natural Suicide A Could not be determined 28a. Date of Injury 28b. Imme of Injury 28b. Imme of Injury 28b. Imme of Injury 28c. Injury at 28c. Injury at							ıral Route Number,						
29a. Certifier 29a. Certifier 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)													
	To th Withir To th	Me	29b. Signature and title of certifier	(1	m				e number			te signed (Month	-
	3	ASHEED : A. ABASSI MD. LAUREL REGIONAL HOSPITAL. LAUREL MD							08				
	6		30. Name and address of person who co	mpleted cause of se	ath (Item 2	(3a) (Type,	Print)	R	EGIONAL	HOSP	ITAL	. Laure	EL MD.
ľ	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 5 2008	2. Registra	ar's Signatu	re Sha	ريك						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 4:45 PM Galina Ordynsky May 9, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Columbia Howard 6313 Young Buck Circle Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) 5 Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 83 558-44-4394 Mar 1, 1925 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumante event, the Medical Fyamicans. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Columbia Howard MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21045 U.S.A. 6313 Young Buck Circle Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give / Year or Dates 2 1 No 1 ☐ Never Married 2 ☐ Married 200 1 🗌 Yes Specify. White δ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Clerical Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Dentel Alezander Plutalov 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eugenia Ordynsky Daughter 6313 Young Buck Circle Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State May 16, 2008 **Hollywood Forever Memorial** 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Bervice License Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending hyvsician and that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 2 Fetal death Month Day in the past 12 months? 5 Other (specify) 2 No 9 Unknown uting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Other significant conditions contril þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: Hospital: 2 ER/Outpatient 3 DOA 2**34.**No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🔲 Inpatient Certification: To 1 🗌 Yes 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide filled i 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner 5

Registrar

State

31. Date filed (Month, Day,

Year)

6

ORIGINAL

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Robert G. Popp /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner mi Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Social Security Number 6. Sex **Funeral** Months Days Hours 1 **5€**M 2 □ F 4/1/18 Maryland 216-05-2879 90 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show notified at 1 ☐ Yes 2 No Director Anne Arundel Linthicum 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be a 21090 USA 228 Homewood Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ≥ No Specify þ 3 MWidowed 4 □ Divorced Year or Dates White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Naval Academy 12 Machinist permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If item 27 is marked other 1 any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Kurrle John Popp ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Keith R. Popp 230 Homewood Rd. Linthicum, Maryland 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 5/14/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** cardiamyopat /Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cupritable list conditions Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed t Division or Vital Records, þ 4 X I nknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No 24a. Was an autopsy perform 25 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be (Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 2**1** No Inpatient 1 Tes Certification: To After this 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Injury Matural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.
neral Director: / 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 24 hours a E Funeral 1 rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hor To the Fune completely f 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 35. Registrar's Signature 31. Date filed (Month, Day, State 16 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year 3:29PM M Robert S. Plummer, Jr. 11, 2008 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Center Randallstown Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months 19€ M 2 □ F Director 207-34-1616 64 Sept. 20,1943 NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. and the first 17 is marked other than "natural", or items 23a or 28a-f show ant: if item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TNo Funeral Director MD **Baltimore** Reisterstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 202 Delight Road 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify þ 3 Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Analyist Social Security Admin 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert S. Plummer, Sr. Dorothy Vane မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenda L. Plummer Wife 202 Delight Road, Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Pages ' Department of h important: if it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet Cem 5/15/08 Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Cine Eline Funeral Home Reisterstown, MD 21136 ans 23a. Rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Imm diate Cause (Final Asphyxia due choking on tooc **Physician** is se or condition re Iting in death) /Medical Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ☐Yes 2☐No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a Was an page 2 s 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Certification: To

Division or Vital Records, P.O. Box $68760 ilde{\mathcal{L}}_{\mathcal{G}}$ Hospital or Attending Physician: After after death Director: filled in by

27.

4 Homicide

Yes 2 1	10	1 ☐ Inpatient 2	ER/Outpatient 3[DOA Other.	4 Nursing Home	5 Residence	6 ☐Other (Specify)
Manner of Death 1 Natural 2 Accident	5 ☐ Pending investigation	THE PROPERTY		28c. Injury at Work? 1 ☐ Yes		Describe how inju	on food
3 ☐ Suicide	6 ☐ Could not be determined	28e. Place of injury - At	home, farm, street, fa		28f.	Location (Street a	and Number or Rural I

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

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Location (Street and Number or Rural Route Number, City or Town, State) Chinas M: US Blud TestauranT

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the calle(s) and manner as stated.

29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

who completed cause of de th (Item 2 a) (Type, Print) by Hill CT. Lutheru; (Ile, Nd 21093)

State Registrar

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Medical

31. Date filed (Month, Day, Year)

6 2008

Registrar's Signature

24 hours a

within 24 hor To the Fune completely fi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 14 2008 Ouarles 3:15A M Jeanette 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 4, 1923 9. Birthplace (State or Foreign Months Days Hours Min 1 ☐ M 2 🔀 F Alabama 85 275-30-7696 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Laurel Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8510 Potomac Creek Road 20724 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: 3 Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Licensed Pratical Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Watson Norval Bracy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Quarles (Daughter) 8510 Potomac Creek Road Laurel, MD 20724 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State Elmwood Cemetery 5-22-2008 4 Donation 5 DOther (Specify) Birmingham, Alabama Name and Address of Facility Leck Funeral Home 601 Sandy Spring Road Laurel, MD 20707 21. Signature of Funeral Service Lice 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final prevmonia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Perca Due to (or as a consequence of): resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 17 No 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation

Physician /Medical Examiner Physician/Medical Examiner burial-trans and the

Physician

/Medical

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Completed

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Funeral

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d other than "natural", or items 23a or 28a-f show event, the Medical Examiner in ust be notified at

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is marked other

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Department of Health Important: If item 27 any Injury or other to once.

1 and 2 should be 1 Health and Mental

Pages 1

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filed within 72 hours after death with

Maryland 21215-0036

Saltimore,

Box 68760.

P.O.

Division of Vital Records,

To the Hospital

requires that the death certificate be executed physician use as attending ō the s been signed b should be deta certificate has N The page or Attending Physician: director. this funeral After within 24 hours after death. To the Funeral Director: A the filled in by

Completed by

Be

Certification: To

Medical

2 Accident

3 ☐ Suicide

4 Homicide

28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be

earne

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier

1 5

determined

29c. License number D62475

29d. Date signed (Month, Day, Year) 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nd 7600 Carroll Avenue Deonarine Takoma Park, MD 20912 2. Registrar's Signature

State Registrar

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Kosser 03:35PM Ke aina Ma 2009 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Burne Battimore Washington Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Director 179-22-0562 PA 6/13/1930 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Queen Anne's Chester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with PO Box 274 21619 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Yes No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Martin Marietta Elementary/Secondary (0-12) College (1-4or 5+) Assembly 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lula Pearl (unkn) ဥ (unkn) (unkn) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n Mr. William Rosser/husband PO Box 274, Chester, MD 21619 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial 5/14/2008 Elkridge, MD 22. Name and Address of Facility Gary L Kaufman Funeral Home 21. Signature of Fundamental Service Lio M01364 7250 Washington Blvd Elkridge MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Bronchieliths obliteraus or auszing disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached the 9□Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? res 2 - No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? after death. 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Wedical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day,

Year)

MAY 15 2008

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DHMH 17 Rev 1/2001

Washington Medical Center

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

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			1- State of Mary Registrar		artment of He ctificate of D			ene g.No.⊴ ∏ ∩ ∩	10000
· (*	Physici /Medi		1. Decedent's Name (First, Middle, Last) Mary R. Randa		٠.		2. Date of Death Month May 15,		3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Sykesv			4c. County of Deat	h
-	Funeral			yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
6	Director		212–30–9782 1□ M 2M F Usual Residence of Decedent	75 Yrs.	Months Days	Hours Min.	March 26	5,1933 Mar	yland
	he Maryland 8a-f show otified at	ector	Md. Carroll	c. City, Town or Loc Sykesvi.	lle				10d. Inside City Limits 1 ŽÍYes 2 ☐ No
	th with t 23a or 2 ust be n	al Dir	10e. Street and Number 710 Obrecht Rd.		10f. Zip Code 21784		10	g. Citizen of What Co	-
980	urs after dea al', or items Examiner mu	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar I ☐ Yes 2☐∰No	spanic Origin? (Spent), Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fijury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. D	lent's Usual Occupa kind of work done do DO NOT use retired) Sewife	tion uring most of worki	ng 1	6b. Kind of Business/	Industry
yland 2	ould be filed Mental Hygi arked other atic event, t	To Be Co	17. Father's Name (First, Middle, Last) John C. Rabbit			18. Mother's Name Rose k		aiden Surname)	
Mar	alth and 27 is m		19a. Informant's Name/Relationship (Type. Print) Ann M. Liskey — Daughter					City or Town, State, 2 sham, AL 3	
imore,	Pages 1 annent of He ant: If item ury or othe		4 Married A Powerties A Powerties And	20b. Place of Dispos cemetery, crem St. Stani	sition (Name of natory or other place islaus Cer	n. May 19	Date 2 2, 2008 F	Oc. Location - City or Seltimore,	Town, State
Balt	permit. Departr Importa any Inji		21. Signature of Furniral Service Ligensee	22 I	Name and Address Eckhardt 1 11605 Reis	of Facility Funeral Caterstown	hapel, F	A. vings Mills	21117
	Physician		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	death. Do not ente	er the mode of dying	, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a con	nsequence of):		,, -			.593
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8760,	ficate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a conditional death)	nsequence of):					
.O. Box 687	ath certii attending or use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf properties to the properties of the proper	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
rds, P	w requires that the de been signed by the a should be detached to	þ	Part II. Other significant conditions contributing to death but no	t resulting in the un	derlying cause giver	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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	ystciar is certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatient	Other	26. Place of Death) nce 6 □Other (Spe	cifu)
Division or	Ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year 2 ☐ Accident investigation	28b. Time of	28c. Injury Work		28d. Describe how		ony)
Divis	al or Attend s after death al Director: ,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - building, etc. (Si		eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my and manner stated.	/ knowledge, death mination and/or inv	occurred at the time restigation, in my op	e, date and place, inion, death occurr	and due to the cared at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the I complet	Me	29b. Signature and title of certifier		29c. License	number 0059943	29	d. Date signed (Mont.	**
	6		30. Name and address of person who completed cause of death	(Item 23a) (Type, F	Print)	nt 307	nesh		1021152
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 6 2008 2 95 MAY 1 6 2008	Signature	de		,	/	
DHN	/IH 17 Rev 1/20	001	111111 2.0						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day 2008 MAY 14, **Physician** 8:00p M THELMA C. RICE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE WOODLAWN 2819 RONA RD. 8. Date of Birth Month Day, Year) 11-14-1906 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Hours Months Days 1□M 2₩F VIRGINIA 101 218-22-4411 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b, County Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director WOODLAWN MD. BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21207 2819 RONA RD. Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ges 1 and 2 should be filed within 72 hours after it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Ite 1 Yes 25 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: BLACK ģ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
-12-College (1-4or 5+) EDUCATION TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY BROWN ARCHER F. CANNADY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2819 RONA RD. WOODLAWN, MARYLAND 21207 BARBARA LAMBERT (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
eny injury or otl 1 XBurial 2 □ Cremation 3 Removal from State ARBUTUS MEMORIAL PARK 5-20-2008 BALTIMORE, MARYLAND 4 Donation Other (Specify) HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A.
1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 21. Signature of Faneral er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi te Cruse (Final disease to ndition resulting in death) Physician Uterine concer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Congested hoor failure 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred in medical Be 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c, Injury at Work? 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

P State

Registrar

31. Date filed (Month, Day, Year)



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Hmu Minn, MD

ral", or items 23a or Examiner must be r

Baltimore, Maryland 21215-0036 ဥ **Physician** /Medical Examiner Examiner Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl signed by details \$ page 2 should Completed certificate funeral director. To Be this Certification: filled in by the Medical State Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day C U Month Beatrice J. Retalis 11:19 am 2008 May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 212 Kennedy Drive Severna Park 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea March 28, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) Months Days Hours 1 □ M 2 □ F Min. 014-24-8846 76 1932 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at MD Anne Arundel Severna Park 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Kennedy Drive 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖫 No ş Specify White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Burnham Frances Cogswell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenna Amero / Daughter 212 Kennedy Drive, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State Cowles Memorial MacCemetery 22. Name and Address of Facility 1 Durial 2 ☐ Cremation 3 DRemoval from State May 19, 2008 Ipswich, MA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Charles L. Stevens Funeral Home Inc. W-Maushall 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Myocardia disease or condition resulting in death) minutes Due to (or as consequence of): Due to (or as a densequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 res 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 | Yes 2 | 1 HO 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 □ No 2 ☐ Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ames 1509 32 Registrar's Signature Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician /Medical Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please T	ype or Print in Bla	ack Ind	lelible lnk	. Ensure Al	II Copies	Are Legible	
1 - For State Registrar	State of Maryland	•	rtment of F tificate of			giene Neg. No. a n n	9 16011
1. Decedent's Name (First, Middle, Last)					Date of Dea Month	th Day Yea	3. Time of Death
MITCHELL	M		ROSENFE	LD or Location of Death	MAY	13 2008 4c. County of De	9:30A M
4a. Facility Name (If not institution, give s 1190 W. NORTHERN 5. Social Security Number 6. Sex	PARKWAY, APT.	711		IMORE If Under 24 Hrs.	8. Date of Birth		N/A Birthplace (State or Foreign
216-05-2205	7. Age (In yrs. las	Yrs.	Months Days	Hours Min.	07/29/	1914	Country) MD
Usual Residence of Decedent 10a. State 10b. County MD N/A		Town or Loc					10d. Inside City Limits 1 X Yes 2 □ No
10e. Street and Number		744	10f. Zip Code	21210		10g. Citizen of What	Country?
1190 W. NORTHERN	PARKWAT, API.	/11	1	Z1Z1U Hispanic Origin? (Spe	ecify Yes or No-		merican Indian.
1 [X] Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🕍 No If Yes, Give Year or Dates:	If	Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black, Wi	
15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give k	O NOT use retire	during most of work d)	ing	16b. Kind of Busines MITCHEL AND PAP	L CHEMICAL
12			PRESIDE		- (Eirot Middle	Maiden Surname)	
17. Father's Name (First, Middle, Last) DAVID		OSENFE		ROSE		,	TRIBER
19a. Informant's Name/Relationship (Type ARNOLD DASHOFF /	COUSIN		•	and Number or Run ROAD, PIKI		er, City or Town, State MD 2120	
20a. Method of Disposition 1 ☑ABurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	^{nete} ľN S'FIT	ition (Name of pators of other place)	ce) (F / 1)	Date E /2000	20c. Location - City	
21. Signature of Funeral Service License	77	22.	Name and Addre	ess of Facility SO		BALTIMOR SON & BROS IKESVILLE,	., INC.
23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. e cause on each line. Due to (or as a constitue)	Do not ente					Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent						
L _d							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregnanc 1 □Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3□	Ectopic pregnand Other (specify) _	у		23d. Date of Month	delivery Day Year
Part II. Other significant conditions con	tributing to death but not resulti	ng in the un	derlying cause giv	ven in Part I.	23e. Did to		e to the cause of death? Probably 4 □Unknown
25. Was case referred to medical examiner?				26. Place of Deat	h (Check only o	ne)	
1 Yes 2 No H		R/Outpatient 8b. Time of Injury	3 DOA Oth			dence 6 ☐Other (S now injury occurred	Specify)
2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hombuilding, etc. (Specify)	e, farm, stre	M 1	Yes 2 □ No	28f. Location (S City or Ton		Rural Route Number,
	ician: To the best of my knowle ner: On the basis of examinatio and manner stated.						
29b. Signature and title of certifier	1.0.	. crd	29c. Licens		. 1	29d. Date signed (Mo	
30. Name and address of person who co	mpleted cause of death (Item 2	3a) (Type, F	Print)	16.1.	(+)	falt.	nd zizak
31. Date filed (Month, Day, Year)	32. Pegistrar's Signatur		/4- (, -3/ (

MAY 1 6 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 3:15A M ROUND 14 SIMEON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE RUXTON OF PIKESVILLE HEALTH CTR. PIKESVILLE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 12/18/1916 1 🕅 M 2 🗆 F MD 91 063-24-7973 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Woden Examinating the notified at 1 ☐ Yes 2 🛣 No BALTIMORE BALTIMORE MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21208 SUDBROOK LANE, #118 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. A Q 3 M Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) TEACHER EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental H Be ROUND ETTA SOLOMON ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3548 BEECH AVENUE, BALTIMORE, MD If item 27 i LEWIS ROUND / SON 20b. Place of Disposition (Name of corpeters cremetors of ather place)
ANSHE KURLAND 20c. Location - City or Town, State 20a. Method of Disposition 6 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 05/15/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signal re of Funeral Se vice Lice see 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prostate Cancer lears **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ¢[®] burial-transi Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy Month Year Por in the past 12 months? 5 ☐ Other (specify) signed by the a 1 Tyes 2 TNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy perfor med? 2**X** No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death After 1 Natural 5 Pending investigation ours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chark

29d. Date signed (Month, Day, Year)

Towson, MD 21204

May, 14, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 8145 A. segraves May 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Road 3158 Tucker treet Har ford County Under 1 Year 8. Date of Birth (Month, Day, Year) Oct. 6, 1929 Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** Birthplace (State or Foreign
Country) Months Days 171-22-2901 1 □ M 2 X F Hours Min 78 Pernsylvania Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Harrford County Street 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be re death with 3158 Tucker Road 21154 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
int: If Item 27 is marked other than "natural", or Itel 1 ☐ Never Married 2 ☐ Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Accountant Franklin Square 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Fisher Catherine Good ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3158 Tucker Road, Street, Maryland 21154 Linda Britain (Friend) 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot once. place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland May 16, 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 COM 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hronic Rend Failure - Discose 3 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death Day Year 5 ☐ Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, δ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has autopsy performed 1□ Yes 2☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 MR Residence 6 Other (Specify) မ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of After t 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 Accident 5 ☐ Pending investigation r death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 15, 2008

DHMH 17 Rev 1/2001

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State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

Vincent A Giminaro, Do 4B North the # 310 Bel Air MD 20015

Registrar's Signature

munio 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 1400544139

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Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director; After this certificate has been signed by the attending physician and
		/

		Please Type or Print in Black Inc		-	•	
		State of Maryland / Department	rtificate of Death			1 0 0 1
		1. Decedent's Name (First, Middle, Last)	illicate of Death	Reg. 2. Date of Death	No.	3. Time of Death
Physic /Med		DOROTHY STEMBLER			Day Year 2008	6:10 AM
Exami	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		Howard County General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Columbia If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Howard 9. Birthr	place (State or Foreign
Funeral Director		212-16-5529 1 M 2 F 96 Yrs.	Months Days Hours Min.	(Month, Day, Ye 08–18–19	ear) Coui	aryland
land land		10a. State 10b. County 10c. City, Town or Lo	cation		1	0d. Inside City Limits
Mary -f sho	to	MD Howard Dayt	on			1 □ Yes 2 X No
h the	Funeral Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?
th wit	je.	4201 Linthicum Road	21036		United S	
r dea	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Nas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
S afte	by F	1 Arried 2 Married 1 Yes 2 Married 1 Yes 2 Married 1 Yes Give 1 Yes Give 1 Year or Dates:	1 ☐ Yes 2 █ No <i>Specify:</i>		Specify:	70 ± 40 0
C LILIS 19-UU30 filed within 72 hours after death with the Maryland Hygiene. The "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	edk	15 Decedent's Education 16a Decedent	dent's Usual Occupation	168	V b. Kind of Business/In	Mhite _{dustry}
hin 72 Nedk	plet	(Specify only highest grade completed) (Give life. L	kind of work done during most of worki OO NOT use retired)	ng		
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id be file ental Hy ked oth	Be (17. Father's Name (First, Middle, Last)		(First, Middle, Mai	•	
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Marid 2 should 2 should 1 shou			ng Address (Street and Number or Rura			Code)
1 and Healt Healt em 2	-	20a Method of Disposition 20b. Place of Dispo	Tymat Court, Laure		and 20/23 c. Location - City or To	own, State
ages ant of t: If It		Purial 2 □ Cremation 3 □ Removal from State	matory or other place) Mar	, I	Tlessides A	· ·
DEBILITIONE, INIGINITIES ALL 13-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once.			2. Name and Address of Facility Gary	v I. Kauf	<u>lkridge, N</u> man Funera	
any per one			IP, Inc., 7250 wash			
34 S. S. W.		23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest.	, all the	Approximate Interval Between
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death certificate e attending physe of for use as the	Med	IF FEMALE:			T	
ath cer attendin or use	an/	23b. Was decedent pregnant 12 in the pact 12 months? 12 Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of deliv	ery Day Year
the a	Physician/Medic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown	Other (specify)			
that the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
On Or VICAL RECORDS, P.O. BOX 08/ ding Physician: The law requires that the death certificate After this certificate has been signed by the attending phys funeral director, page 2 should be detached for use as the	ed by			1 ☐ Yes	2 No 3 Pro	bably 4 Wunknown
law reas bee	Completed			24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
The The page	E			performed	d? death?	2□ No
Or VITAL Physician: 1 this certificat al director, pa	Be (25. Was case referred to medical examiner?		(Check only one)		
Physic This c	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier 27. Manner of Death 28a. Date of Injury 28b. Time o		me 5 Residence 28d. Describe how	e 6 Other (Speci	fy)
ding h. After funer	ion	1	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	200. Describe now	injury occurred	
OVISION Or Attending after death. Director: Afte	fica	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, str	reet, factory, office	28f. Location (Stree	et and Number or Rui	al Route Number,
tal or s afte al Dir	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	лагеј	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical (29a. Certifier (Check only (Ch	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the causered at the time, date	se(s) and manner as	stated. to the cause(s)
thin 2,	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month	Dav. Year)
¥ ¥ ¥ 8		M. G. MO	00063653	-50	May 14, 2	208
(î		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		, ,	7
8		Shawn Evans 5755 Cedar	Lane Columbia	Maryl	and 210	44
	tate	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, \$\frac{1}{2}\text{Signature}\$ 31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Regis	trar	MAY 1 5 2008 Marie &	w .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 133 AM 3008 MAN JURL AMES 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death NEBIC ALTMORE N/A 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 7, 194 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Days Maryland 220-36-5179 1940 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No N/A Baltimore Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21230 1434 Woodall Street USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 【 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: White 3 ☐ Widowed 4 ☐ Divorced VietNam 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N.A. Gossmann Printing Printer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ernest Sauble Eleanora Schaaf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 Tigerwood Court, Baltimore, Maryland 21234 Dea1 (Niece Anna Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Md. Veterans Cemetery 5/19/08 Garrison Forest, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kevin E Ecker 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): MEDINOMI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Extremospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 2 □ No 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an cate has b page 2 s autopsy 1☐ Yes 2MNo Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3∐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 🗌 Homicide 24 hours after To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifiq 30*0*% 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PINT PAUL PLACE gistrar's Signatur Registrar's S Year) State 2008 16 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 15:10 PM ^M Donald Gilbert Snowden 05 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Air, I'm <u> Upper Chesapeake Medical Center</u> Maryland Harford 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Min Director 140-20-2202 78 06/12/1929 New Jersey Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Kingsville the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Jerusalem Glen Court U.S.A. 21087 death 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No Korean If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 □ Divorced Specify: Year or Dates: Conflict White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) 12 College (1-4or 5+) Electrical Engineer Dupont Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Gilbert Gladstone Snowden Eleanore Elizabeth Biddle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a.
Important: If item 27 is.
any injury or con-Sharon L. Babcock (daughter) 5 Jerusalem Glen Court - Kingsville, MD laltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Saints Cemetery 05/14/2008 Newark, Delaware 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 60 11750 Belair Road - Kingsville, Maryland CLO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 9ade one year /Medical Due to (or as a cov equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year ed by the a detached f 5 Other (specify) P.0 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autonsy perforn 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 Inpatient this funeral 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Certification: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending investigation hours after death. 1 ☐ Yes 2 ☐ No I Director: 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours at ne Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the the 29b. Signature and title of pertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 1/2001 6025

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔀 🗓 🗓 🕃 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** May 10, 2008 12:50 P M William J. Simon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Carriage Hill of Bethesda Bethesda If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Days Hours Months 1 X M 2 □ F Nov. 13, 1912 Illinois 95 Director 066-16-6601 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the "natical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Kensington Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 20895 United States 4230 Everett Street Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 X Yes 2 □ No If Yes, Give altimore, Maryland 21215-0036 1 □Yes 2 No White Specify: þ WWII 3 X Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) National Highway Department of Heath and Mental Hygiene Important: If item 27 is marked other than any Injury or other traumatic event, the Maonce. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Users Federation Lobbyist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cora Miller James Simon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3106 Lee Street, Silver Spring, Maryland Wendy Lee Simon/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition May 14. 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Montgomery Crematorium Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 permit. 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee William M01173 omes 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final Failure to Thrive **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Due to (or as a consequence of) Hospita or Attending Physician: The law requires that the death certificate be executed 24 hours after dearh.

Funeral Director After this certificate has been signed by the attending physician and Examir Congestive Heart Failure that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Prostate Cancer Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hematuria autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 💢 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🕅 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. the within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 12, 2008 D35579 19+1 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) 6844 Tulip Hill Terrace, Bethesda, Maryland Susan Miller, M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 6

Registrar's Signature

2008

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State of Maryland / Department of Health and Mental Hygiene

		•	1 - State of State of Registrar		artment of Healt rtificate of Deal	th	Reg. No.	8 16013	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Iris S. Brockington Shelto	n		2. Date of D Month	Day Ye	3. Time of Death	
1	Examin		4a. Facility Name (If not institution, give street and num Northwest Hospice	ber)	4b. City, Town, or Location Randalls	on of Death LOWN	4c. County of Death Baltimore		
	Funeral Director		5. Social Security Number 217-62-6220 6. Sex 1 ☐ M 2√5xF	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 1 Yea	der 24 Hrs. 8. Date of B rs Min. (Month, D Oct. 22	irth 9 (ay, Yea <i>r</i>) 1954	Birthplace (State or Foreign Country) MD	
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits	
	the Mar 28a-f st	Director	MD Baltimore		Pikesville		10g. Citizen of Wha	1 KN/es 2 □ No	
	23a or	ral Dii	4600 Debilen Circle Apt.		21208		USA		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. It. Midcel Ever, but it is infilled at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced 12. Was Deceder Armed For 1 □ Yes. If Yes, Giv. Year or Da	2 ³ E ³ tNo e	Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 □ Yes 2 HNo Spec		14. Race - Black, \ Specify: B	American Indian, White, etc. Black	
21215-0036	ithin 72 hc ne. nan "natu l Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary Secondary (0-12) College (1-	(Give	dent's Usual Occupation kind of work done during r DO NOT use retired) barmaid	most of working	Garrison L		
and 21	d be filed within and Hygiene.	Be	17. Father's Name (First, Middle, Last) Maxie Brockington			other's Name <i>(First, Midde</i> Dorothy	e, Maiden Surname)	Noting C	
Maryland	1 and 2 should be Health and Mental em 27 is marked o ther traumatic ev	To	19a. Informant's Name/Relationship (Type. Print) Joseph Bernard / Guardian	1	ng Address <i>(Street and Nu</i> Oakley Avenue;				
Baltimore,	Pages 1 ament of Heament: If Item		20a. Method of Disposition 1 → Deburial 2 □ Cremation 3 □ Removal from S 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispondentate 20b. Place of Dispondentate Mount Zion	osition (Name of matory or other place) Cemetery	Date 05/16/2008	20c. Location - Cit Baltimore,		
Balti	permit. F Departm Importar any Injur		21. Signature of Funeral Service Licensee		2. Name and Address of Fa 638 N. Gilmor S				
· Angli	Physician /Medical	a y	arrest,	Approximate Interval Between Onset and Death					
	artificate be executed ing physician and seas the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c.	or as a consequence of): or as a consequence of): or as a consequence of):	nodefaery	y Syndrome			
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on of	To the Hospital or Attending Physician: The within E4 horus after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Certification: To	27. Manner of Death 28a. Date of			28d. Describ	e how injury occurred		
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	To the within 5	Me	29b. Signature and title of certifier		29c. License numb	per 1	29d. Date signed (Month, Day, Year)	
	3	1	30. Name and address of person who completed cause	10		751	144	2008	
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ME	uicai Exami	ner	Sharon 4a. Facility Name (if not instit		pson		- 14	4b. City, Town,	orlo	cation of		May 12, 20		. County of De	eath	
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	d with	Com	17. Father's Name (First, Mid	idle, Last)		!		TOMEMAX	-	3.Mother's	Name (First, Middle, I			1110	
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	21 ould be d Men s mar	2	19a. Informant's Name/Relati			198	. Mailin	g Address (S	treet a	and Numb	er or Ru	ıral Route Nun	nber, C	ity or Town, S	state, Z	Lip Code)
	MD d 2 sho Ith and n 27 is		Mrs. Erica S	immers/Dau	ghter			Newha						-		
			20a. Method of Disposition 1 Burial 2 Crema	etion 3 Remova	from State			sition (Name of her place)	f ceme	etery,		Date	20c.	Location - Cit	y or To	own, State
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	tal Records, P.O. Box 6876i cian: The law requires that the death certificate certificate has been signed by the attending phy ector, page 2 should be detached for use as the t	ð										1 Ye	s 2	No 3	Proba	bly 4 🗸 Unknown
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	Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier (Check only 1 Certifyin	ng Physician: To the t	oest of my ki	nowledge, de	ath occu	rred at the tim	ie, dat	e and pla	ce, and	due to the cau	se(s) a	nd manner as	state	i.
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			Theodore M. King,		Registrar's	lical Exam			ı otre	set, Dal	arnore	e, MD 2120				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day i3 Year **Physician** C835 PM LILLIE MAY TURNER 2000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA (UMMC) CITY BALTIMORE UNIVERSITY HOSPIVIL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) (ANKNOUN) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 🗆 M 2 🖺 F 220-76-5863 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show other traumatic event, the Medical Examiner, ust be notified at 1 ZYes 2 ☐ No Completed by Funeral Director MARYLAND 10g, Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with Innent of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: If Yes, Give Year or Dates: 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) THGRADE 18. Mother's Name (First, Middle, Maiden Surname) (MN - UNKNOWN) 17. Father's Name (First, Middle, Last) Be ODGER ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee iamo ULTON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPOXICA **Physician** /Medical Due to (or as a consequence of): Examiner 24 hours Pulmonary E dem a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Stenosis UNKNOWN and Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 █ No 23d. Date of delivery 3 Ectopic pregnancy Dav 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 Probably 4 ☐ Unknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 □ Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 🕅 Natural 5 Pending 1 ☐ Yes 2 No nours after death.

neral Director: A investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

EZANA AZENE 31. Date filed (Month, Day, Year) 32. Registrar's Signature

JUNIVERSITY OF

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MARYLAND MEDICAL

22

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 329d Per Phy G879 5/16/08 Allicate of Death

Physician Department of Health and Mental Hygiene. Director Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director To Be Completed by Funeral Director To Be Completed by Funeral Director	Social Security Number Unknown Sual Residence of Decedent Da. State MD De. Street and Number 921 Armistead	Way 10c. Ci Ba Way 12. Was Decedent Ever in U Armed Forces? 1	Yrs. ity, Town or laltimo J.S. 13 16a. Dec (Gin life) 19b. Ma 79 Place of Discemetery, c 3ayvi ath. Do not e	Location Ore Cit 10f. Zip Code 2120 3. Was Decedent of If Yes, specify C 1 Yes, specify C tedent's Usual Occepte kind of work do b. DO NOT use ret Homem 52 St. position (Name of rematory or other, ew Crem 22. Name and Ad PA, 213	y e 5 of Hispanic Origin? Cuban, Mexican, Pue No Specify: cupation one during most of witired) 18. Mother's N Glady: ceet and Number or Monica fplace) atory 5 ddress of Facility B 4 Willo	S. B. Date of Bir (Month, Date (Month, Date (Month, Date (Month), Date (Month), Date (Month), Date (Month), Dure (th Year) 1928 10g. Citizen of US 14. Rae Bla Special 16b. Kind of E OWn o, Maiden Surna per, City or Town ndalk, 20c. Location Balti Ashton g Rd,	9. Birthplace (State or Fore Country) WV 10d. Inside City Lim 1X Yes 2 What Country? A ce - American Indian, ack, White, etc. if: White Business/Industry Home me) n, State, Zip Code) MD 21222 - City or Town, State more, MD FuneralHom
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death o	23b. Was decedent pregnant in the past 12 months? 1 \(\subsection \text{yes} \) 2 No 9 \(\subsection \text{Unknown} \)	23c. If yes, outcome pf preging 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death	3 □Ectopic pregna 5 □ Other (specify				Date of delivery Month Day Year
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ate has b page 2 sl							opsy formed?	o. Were autopsy findings avail prior to completion of cause death? 1 □ Yes 2 □ No
certificate rector, pag	25. Was case referred to medical examiner?					Death Check onl	one	
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	MU			RE	000		MAY (06 2000
2 30	30. Name and address of person who co	ompleted cause of death (Ite	em 23a) (Ty	pe, Print)				
	RMICHAEL DORS	32. Registrar's Sig	TEAN	AVRIVIL	RAUM	ork m	212	224
	31. Date filed (Month, Day, Year) MAY 1 2 2008				Dut not have			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10^{ay} 2008 АМ 1:10 May Frances Silverman Vaughan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Collingswood Nursing Center Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
New York 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** 1 □ M 2 🗓 F Months Days Hours July 3, 1922 Director 087-16-6103 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location d other than "natural", or items 23a or 28a-f sho event, the "teofical Examination or set to notified at Director 1∭Yes 2 □ No Maryland Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 102 Evans Street 20850 United States Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces? 1 ∐Yes 2 XNo Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: Specify: ş 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Deputy Director, Department Prince William Elementary/Secondary (0-12) College (1-4or 5+) Social Services County, Virginia 5+ permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linity or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Saul Silverman Pearl Silver ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Vaughan / Son 519 W. Spring Street, Woodstock, Virginia 22664 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Baltimore National 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State May 14, 2008 | Baltimore, Maryland 4 Donation 5 Dother (Specify) Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility acility Robert A. Pumphrey Funeral Home/ 300 West Montgomery Avenue, Rockville - 2805 Rockville. Inc. Maryland 20850 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia /Medical Due to (or as a consequence of): Examiner Failure to Thrive Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2 XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 [XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the death certificate be executed Box 68760, Ö ₫. Division of Vital Records, Hospital or Attending Physician:

burial-tran and attending physician the as use Po detached the signed by t peen : cate has b certificate within 24 hours after death.

To the Funeral Director: After this filled in by the funeral

show

death with the

filed within 72 hours after

and Mental Hygiene.

Baltimore, Maryland 21215-0036

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Medical

Registrar

31. Date filed (Month, Day, Year) State

29a, Certifier

29b. Signature and title of certifle

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

D0062435

May 12, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sayed Elsayyad M.D. 9715 Medical Center Drive # 201, Rockville, Maryland 20850

MAY 6



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2008 **Physician** May 15, 11:35 A M Margaret E. Wells /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Valkersville

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Ye.
Sept. 17, Frederick Walkersville Glade Valley Nursing & Rehab. 9. Birthplace (State or Foreign Country)
New Hampshire 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Year 1 □ M 2 1 F 001-14-637 93 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with USA 21701 7994 Serenity Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iten 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. ^{Specify:}White Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Cavanaugh Joseph Egan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7994 Serenity Court Frederick, MD 21701 Richard C. Wells/son Department of Health Important: If item 27 any injury or other tronce. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Chesapeake Crematory | 05/16/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) neumania /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Uniscase or injury that initiated events Due to (or as a consequence of): Examiner burial-tra resulting in death) Last Due to (or as a consequence of): Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. Division or Vital Records, P.O. After after death. the filled in by 24 hours a within 24 hou

To the Fune
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Certification: To

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and

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Registrar

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and manner stated.

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28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add

6 ☐ Could not be

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Day, Year) 1 6 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 📋 🗍 🖺 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month **Physician** 3:30 AM 200 Dorothy E. Waghelstein 5 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Square Paltimore Hospi Kosedale tal If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min. 1□M 2**X**F 186-09-8926 Director 02/04/1919 Delaware Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Baltimore Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21236 USA 27 Grandee Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married e (STE) ししのたの Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White þ 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked other any injury or other trauments. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William E. Windsor Alice Taylor ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Grandee Ct. Baltimore, MD 21236 David Fisher / nephew Magh Baltimore, I 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Arithgton National 05/27/08 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA Cemetery 22. Name and Address of Facility
Evars FUneral Chapel & Cremation Services nature of Funeral Service Licenses 21. Sig 8800 Harford Rd. Parkville, MD 21234 ant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. mmediate Cause (Final disease or condition resulting in death) Sepsi **Physician** /Medical Due to (or as a consequence of) **Examiner** rinary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an was a... autopsy performed? 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 5 Pending investigation

Box 68760, Records, P.O. Division or Vital within 24 hours after death. To the Funeral Director: After

> State Registrar

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and

6 ☐ Could not be

30. Name and address of person who completed of

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31. Date filed (Month, Day,

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

use of death (Item 23a) (Type, Print)

and manner stated.

1 ☐ Yes 2 ☐ No

🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year Williams Danny Wayne 9, 2008 5:05P May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Dundalk 8638 Sandy Plains Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Min. 1**∑** M 2□ F Months Davs Hours Sept. 3,1961 Maryland 216-82-9638 46 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 1 ☐ Yes 2X No Baltimore Maryland Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8638 Sandy Plains Road United States 21222 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ∐Yes 2ไ∑No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Co. Machine Operator 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian Milligan George W. Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8638 Sandy Plains Road Dundalk, Maryland 21222 Mrs. Doris E. Williams (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2√Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Service Corp: 05-15-2008 Towson, Maryland Hilltop 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk Inc. 7922 wise Avenue Dundalk Maryland 21222 23a Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE INFARCTION MYOCARDIAL MOUR. Due to (or as a consequence of): ATHEROSCLEROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) DIABETES MELL Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ONG 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 □ N/a 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 NA10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

/Medical **Examiner** physician and the burial-transit Box 68760, pe as attending use jo P.O. I the detached signed by Records, pe peen

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Baltimore, Maryland 21215-0036

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ir than "natural", or items 23a or 28a-f shout a Medical Examination to must be notified at

25. Was case referred to medical examiner? 1 ☐ Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wise Avenue, Baltimore, MD Deepak Seth

DHMH 17 Rev 1/2001

Medical

State Registrar

DHMH 17 Rev 1/2001

ION Greene St Baltimore MD 2120

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Bock

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31. Date filed (Month, Day, Year)

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Physician /Medical Examiner The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760容 physician the use as

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Pages 1 Department of Important: If it any injury or o

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3altimore, Maryland 21215-0036

Physician/Medical Completed by Certification: To Be

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25	. Was case referred to examiner?	medical				26. Place of Dea	ath (Check only one)
	1 ☐ Yes 2 No		Hospital: 1 Inpatient 2	ER/Outpatient	3 🗆 [DOA Other: 4 Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)
27.	2 Accident	Pending investigation		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	6 ☐ Could not b determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)
20	a Certifier 190	ertifying Ph	veician: To the best of my kno	wiledge doath c	COLLEG	ad at the time, date and place	and due to the sever(s) and many a state of

one)	and manner stated.
29b. Signature and title of certifier Clexender	Mulamul

(Check only

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 10065819

05/08/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 Medical Center Drive, Rockville, Maryland Alexander Mulamula, M.D. 20850

State Registrar

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31. Date filed (Month, Day, Year) MAY 1 6



		ı.	State of Maryland / E 1 = State Amend Item 1 per dr., g879,05	Department of Health and N COMPETE of Death		ene g. No. 2008 16029
	Physicia	an		nankwah	2. Date of Death Month	Day Year 2 10 12 PM
\$	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			TATE HOUSE	LINTHICUM thday) If Under 1 Year If Under 24 Hrs.	9 Date of Birth	ANNE ARUNDEL 9. Birthplace (State or Foreign
36	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, OCT 1	1964 ACCRA GHANA
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location		10d. Inside City Limits
	Mary I-f sho fied a	tor	MD PRINCE GEORGE'S	LAUREL		1 No Yes 2 No
	or 28s	Director	10e. Street and Number	10f. Zip Code	10	Og. Citizen of What Country?
	s 23a nust t		9520 MUIRKIRK ROAD # 202	20708	pecify Yes or No-	USA 14. Race - American Indian,
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1	13. Was Decedent of Hispanic Origin? (Stif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White, etc. Specify: BLACK
Maryland 21215-0036	hin 72 hou e. an "natur a Medical E	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)		16b. Kind of Business/Industry
2	ed wit ygien ner tha	Con	2 yrs	SECRETARY	ne (First, Middle, N	PRIVATE Maiden Surname)
and	ould be fil Mental H arked oth atic even	To Be	17. Father's Name (First, Middle, Last) FELIX K. AMANKWAH		PONSAH	nadon Gurtano)
	S as S	1		. Mailing Address (Street and Number or Ru 520 MUIRKIRK ROAD #		
altimore,	Pages 1 and 2 nent of Health ant: If item 27 i		1 Thursd 2 Toronation 2 Temporal from State	f Disposition (Name of ry, crematory or other place) RECTION CEMETERY 5/3		20c. Location - City or Town, State CLINTON, MARYLAND
Balti	permit. Pages Department of Important: If if any injury or once.		21. Signature of Funeral Service Licensee	7474 LANDOVER ROAL) LANDOVE	
4	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	not enter the mode of dying, such as cardiac	or respiratory arre	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence	of):		
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8760,	cate be executed physician and s the burial-transit	dical Ex	Due to (or as a consequence	01).		
9	rtificat ng phy e as th	Medi	IF FEMALE:			
Division or Vital Records, P.O. Box	w requires that the death certific been signed by the attending p should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
ds, P.	The law requires that the ate has been signed by the page 2 should be detache	d by Ph	Part II. Other significant conditions contributing to death but not resulting	n the underlying cause given in Part I.		bacco use contribute to the cause of death? es 2 No 3 Probably 4 Unknown
Recol	he law req e has beer age 2 shou	Completed			24a. Was a autops perfor	sy prior to completion of cause of
<u>ta</u>	ian; T	Be C	25. Was case referred to medical examiner?	26. Place of De	ath (Check only or	
ر ا	hysic this ce al dire	မ	1 ☐ Yes 2 ☑ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/O			ence 6 DOther (Specify) 6 50 16 2 ow injury occurred
on	ding h. h. After funer	tion:		Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	200. 20002011	on many social co
Divisi	l or Atten after deat Director	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, f building, etc. (Specify)	arm, street, factory, office	28f. Location (S City or Tow	treet and Number or Rural Route Number, in, State)
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge (Check only one) Certifying Physician: To the basis of examination a and manner stated.	le, death occurred at the time, date and place nd/or investigation, in my opinion, death occ	e, and due to the curred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within To the comp	Me	29b. Signature and little of certifier	29c. License number	2	29d. Date signed (Month, Day, Year)
0		l q	30. Name and ad yess of person who completed cause of death (Item 23a)	(Type, Print)	, –	711615.
1			JAJUA TIKESOMO GUOV	Sestank RJ Sc	, the SO.	DAME BY ENGLISH OF
	Sta Regist	ate rar	31. Ďaté filed (Month, Day, Year) APR 3 0 2008	E Comment		

Horty Amankwah

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amend item of per door 5 19b per the all on 6 11-08 vt.

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			For State Registrar	State	or Mary			nt of H		vientai Hy	giene Reg. No.	2018	16030
	Dharini		1. Decedent's Name (First, Mic	ldle, Last)						2. Date of De	eath 27	Year	3. Time of Death
	Physicia /Medic		Bernice			mes				April	21,	2008	18:30 P M
	Examin	er	4a. Facility Name (If not institute Prince George:	-				, Town, or ever1	Location of Death			County of Deat ince Ge	
	Funeral		5. Social Security Number	6. Sex	_	yrs. last birthday)	If Und	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th Year)9	14 9. Birt	hplace (State or Foreign untry)
	Director		431 -22 -0145	1 □ M 2√€	F	93 Yrs.	Working	Dayo		Decemb			iisiana
	land ow		Usual Residence of Decedent 10a. State 10b. Cour	ity	10	c. City, Town or Lo	cation						10d. Inside City Limits
	Mary a-f sh	ctor	MD Princ	ce George	s	Seabroo	k						1 🙀 Yes 2 🗌 No
	or 28	Director	10e. Street and Number	DD #100			10f. Z	ip Code				en of What Co	untry?
	s 23a		9955 Goodluck		Na and and Trees	- 110 10 10 10 10 10 10 10 10 10 10 10 10	W D	207		anife Van or Ne		USA 4. Race - Ame	rican Indian
920	within 72 hours after death with the Maryland glene. Than "natural", or items 23a or 28a-f show than "natural be natified at the Medical Evant he must be natified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ M 3 ☑ Widowed 4 ☐ Divorce	arried Armed	Decedent Ever of Forces? os 2 2 No Give or Dates:	i		ecify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)		Black, White	
2-0036	72 hou	Completed	15. Deced	ent's Education hest grade complete	ed)	16a. Dece	dent's Us	ual Occup	ation during most of work	dina	16b. Kir	nd of Business/	Industry
.7	ne.	mpl	Elementary/Secondary (0-12) Colleg	e (1-4or 5+)				turing most of worl !) - •	9		Privat	
0	Hygie v Hygie Sther i		17. Father's Name (First, Midd		yrs	LOS	smeto	logi	18. Mother's Nam	ne (First, Middle	, Maiden S		.e
<u> a</u>	Ald be Aental rked c	To Be	Guy Nel						Margare	et 1	White		
Maryland 21	2 shou and N is ma	-	19a. Informant's Name/Relation			19b. Mailir	ng Addre	ss (Street	and Number or Ru	ral Route Numb	er, City or	Town, State, 2	Zip Code)
ა _ დ	and Health		D. Virginia :	Nelson /		9955 20b. Place of Dispo	5 God	dluc	k Rd., Se	eabrook Date	, MD	20785 cation - City or	Town State
ם סב	ages ant of l		1⊠ Burial 2 ☐ Crematio		a I	cemetery, cree Harmony M	natory or	otner plac	e) :			•	
Baltimore,	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If Item 27 is marked other it any injury or other traumatic event, Ib		4 □ Donation 5 □ Other 21. Signature of Funeral Servi			22	2. Name	and Addres		nnson &	Jenk	ins Fur	neral Home 20011
			23a. Part 1. Enter the disease, shock, or heart failure. L	or complications in	at caused the	-						., DC 2	Approximate
	hysician /Medical	8 17	shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	a. As	septate								Interval Between Onset and Death Minutes
	xaminer					Disorde	r						Months
-	Di ii	iner	Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury	Due	to (or as a co	nsequence of):		=					Vacua
	xecur al-trans	Examiner	that initiated events resulting in death) Last			elerotic	Hear	t Dis	ease				Years
09/89	ricate be executed g physician and is the burial-transit	edical E		d. Cl	ronic	Renal Fa	ilur	e					Months
20	ing ph	Medi	IF FEMALE:			-							-
O. Box	w requires man me deam cermicate be executed to be executed to be signed by the attending physician and should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ U 4 <u>☐</u> P	outcome of p ive birth 2 L regnant at tim Inknown	Fetal death 3	☐ Ectopic ☐ Other (pregnanc specify)	у		2	3d. Date of de Month	livery Day Year
7 . }	ed by detach		Part II. Other significant cond	itions contributing !	o death but no	ot resulting in the u	nderlying	cause give	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
ďS,	requires that the leen signed by the nould be detached.	d by								1 🗆	Yes 2	No 3□P	robably 4 🗌 Unknown
မှ ၂	sician; The law rec certificate has bee irector, page 2 shot	Completed	- 51					-				24b. Were au prior to death?	utopsy findings available completion of cause of
Iga	ertifice ctor, p	Be C	25. Was case referred to medi examiner?	cal					26. Place of Dea			12100	2 2 3 10
5	al d	2	1 ☐ Yes 2 😿 No			2 K ER/Outpatier			4 LI Nursing H				ecify)
	D 0 0	tion	27. Manner of Death 1 ☑ Natural 5 ☐ Pen-	/8	ate of Injury Month, Day, Ye		M	28c. Injur Worl	yat ⟨? Yes 2 □ No	28d. Describe	now injury	y occurred	
ISINIC	or Attending rafter death. Director: After in by the funera	Certification:	3 ☐ Suicide 6 ☐ Cou	ld not be 28e. Pl	ace of Injury - uilding, etc. (S	At home, farm, str Specify)			100 2	28f. Location City or To	(Street and wn, State)	d Number or R	ural Route Number,
	of the hospital of Attendin within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Medical Co		ying Physician: To al Examiner: On the and n		amination and/or in							
4	within To the comple	Me	29b. Signature and title of certi				2	9c. Licens	e number		29d. Dat	e signed (Mont	th, Day, Year)
	15		1/100	K (3~			D310	069		Apı	ril 30,	2008
	000		30 Nam and address of pers					1 x 2 N	m 2070s				
	200	1 10	Dr. George Bo		lospita 2. Registrar's		ever	ту, М	ID 20785				
	Sta Registr		MAY 0 1 2008	6	L. Negistiai S	diane !							

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			For State Registrar			and / Dep <i>Ce</i>	artmer	nt of H		and Me	ental Hy	Reg. No.	008	BALDONAU S	031
	Physici	an	1. Decedent's Name (First, Middle, L	ast)							2. Date of De Month	eath 26	2008		of Death A M
	/Medic	al	Ernestine A	rrington			4h Cih	Tour	r Location o	of Death	04		County of Dea		A M
	Examin	er						urel		or Death			ince G		
* ***	Funeral		Laurel Regiona 5. Social Security Number 6.	Sex		rs. last birthday) If Unde	r 1 Year	If Under		8. Date of Bir (Month, O	rth		rthplace (State	e or Foreign
	Director		240-72-6852	1 ☐ M 2 🔯 F	62	Yrs.	Months	Days	Hours	Min.	08 16			rth Ca	
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or L	ocation							10d. Inside	City Limits
	Maryli f sho	ro		Georges		Laure1								1 <u>F</u> Y	es 2 No
	r 28a-	Director	10e. Street and Number				10f. Zi	p Code				10g. Citi	zen of What C	ountry?	
	filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or Items 23a or 28a-f show int, the Marikal Exam. are must be calified a	ai D	8809 Hawthorne	Court #1	3-3		20	708				US	A		
	r dea	Funerai	11. Marital Status	12. Was Dec Armed F	edent Ever is	n U.S 13.	Was Dece	dent of H	lispanic Ori an, Mexicar	igin? (Spe n, Puerto F	cify Yes or No Rican, etc.)		14. Race - Am Black, Wh		
20	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ☐ Yes If Yes, Gi Year or D	ve				Specify:				Specify: B	1ack	
21212-0036	turai	ed t	15. Decedent's	<u> </u>	d(85.	16a. Dece	edent's Usu	ial Occup	ation			16b. Ki	nd of Busines	s/Industry	
2	hin 72	piet	(Specify only highest s Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give	B kind of w DO NOT i	ork done ise retired	during mos d)	t of workir	ng				
	or the	Completed		1 Y		Di	etici	.an					sing H	ome	
yland	e d fa	Be	17. Father's Name (First, Middle, La	st)							(First, Middle		Sumame)		
<u>S</u>	should be nd Mental i marked	7	Denise Pender	(Time Oriet)		105 140	inn Addres	- /Ctanat			Steve		s Town State	Zin Coda)	
Mar	od 2 st lith and 27 ts n r traun		19a. Informant's Name/Relationship Stephanie Robins		ater		•				am Md		r Town, State,	ZIP COUE)	
	Hea Hea		20a. Method of Disposition	on, baug	20	h Place of Dien	ocition /A/s	ma of			ate MG		cation - City o	r Town, State	
Ē			1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State F	cometery cre lamilton ardens	"Bur	lal	(05-03	-08	Wil:	son, NO	3.	
Baitimore,	permit. Page Department of importent: If eny injury or once.		21. Signature of Funeral Service Lic	ensee	-	2	22. Name a	nd Addre	ss of Facili			's F	uneral	Home	
מ	882.58		Julia P. M	aish	ell	4	217 9	th.	St. N	1.W.	Washin	gton	, D.C.	20011	
/on,	Physician /Medical /Medical /Medical Examiner / Spring /	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	(or as a con	sequence of): sequence of): sequence of):	Sma11	L Cel	L1 Lur	ng Ca	ncer			Onset ar	n Death
O. Box 68	The law requires that the death certificat tie has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		oirth 2 🗍 F	etal death 3	⊟Ectopic p □ Other (s		/				23d. Date of d Month	elivery Day	Year
ds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions Malignant Ple			resulting in the	underlying	cause giv	en in Part I				ise contribute □ No 3 □ I	_	of death?
Vital Records	s bee	Completed	Acute Cerebro	ovascula	r Acci	dent					24a. Wa		24b. Were	autopsy findin	gs available
ř	The la	mo:	Hypertension			- "					perf	opsy formed? 2⊈ No	death?	completion on s	on cause of
<u> </u>	sician: The law certificate has t irector, page 2 s	Bec	25. Was case referred to medical examiner?								(Check only	one)			
- 	Physician: r this certifice ral director, p	ဥ	1 ☐ Yes 2 ☐ XNo	21		2 ER/Outpatie							6 ☐Other (Sp	ecity)	
	ttending F death. tor: After the funera	ion:	27. Manner of Death 1 Anatural 5 Pending		of Injury th, Day Yea	r) 28b. Time Injury	of M	28c. Injur Wor	yat rk? ∣Yes 2.∐		28d. Describe	how injur	y occurred		
UNISION	A 20 yd	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Plac	of Injury - Aing, etc. (Sp	At home, farm, s ecify)			163 2			(Street an own, State	d Number or I	Rural Route N	lumber,
	To the Hospital or A within 24 hours after of the Funeral Directompletely filled in by	Medicai C		Physician: To th aminer: On the b and mar											e(s)
	To the within 2 To the complet	Me	29b. Signature and title of confiler			10 8			se number				te signed (Moi	-	
)			MO	1	DASS	649	186		2	1-30	-08	
)	(3)		30. Name and address of person wh	o completed cau	se of death (Item 23a) (Type	, Print)	0	,	9 4	2.	-	1-30 Suited	2,00	1044
			31. Date filed (Month, Day, Year)	A 32 1	1070 Registrar's S	ignature	11/4	8A-1	uke	NT 9	noku	Ay,	Suite &	00 (a) un	nbiall U.
	Sta Registr		APR 3 0 2008	Kenn	B	And	7					•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State AMEND#9, perFH, 5/12/08, DPS, MbCo Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:15 25, 2008 April James Bernard Allen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Lank Inton Funeral 1**⊠** M 2□ F Franklin, May 23, 1931 76 Director 578-40-2166 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County r 28a-f show notified at 1⊠Yes 2□No Director Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Examiner must be r 20904 U.S. Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23s by Funeral 315 Beaumont Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∀es 2 No If Yes, Give 1952–54 1 ₩ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XNo Specify: Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 3 Civil Engineer Private d other i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hasty Perry James A. Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any Injury or other trau once. 9904 Ocean Sand Ct. Laurel, MD 20723 Steven Allen / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) May 1, 2008 Suitland, MD Lincoln Memorial 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee Indre 7400 Georgia Ave., N.W. Washington, D.C. 20012 Jus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardio Pulmonary Arrest /Medical Due to (or as a consequence of): **Examiner** Septic Shock Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Respiratory Failure physician and the burial-trans Due to (or as a consequence of) by Physician/Medical 38 IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth Month Year Day in the past 12 months? 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 10 21 No Yes 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 27. Manner of Death

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, After 1 24 hours after death Puneral Director: within 2 To the

Baltimore, Maryland 21215-0036

5 ☐ Pending investigation 1 🙀 Natural 1 ☐ Yes 2 ☐ No 2 Accident

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide tgl Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D065069

29b. Signature and thie of certifier

29c. License number 29d. Date signed (Month, Day, Year)

April 29, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Sirak Lemma 1500 Forest Glen Rd. Silver Spring, MD 20910

State Registrar

Medical

31. Date filed (Month, Day, Year) MAY 0 2 2008

6 ☐ Could not be

3 ☐ Suicide



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			1 - For State Registrar	State of Maryland /	Department of Health and Certificate of Death	Mental Hygien Reg. N	2000 10000
	Dhunis		1. Decedent's Name (First, Middle, L	ast)	1	2. Date of Death Month D	3. Time of Death
	Physici /Medi		Betty	A. 41	len	4 2	9 2008 2025
	Examir		4a. Facility Name (If not institution, ga	ve street and number)	4b. City, Town, or Location of Deal		c. County of Death
			4311 Marke	+ 5+.	Snow Hill		Worcester
	Funeral			Sex 7. Age (In yrs. last	Months Days Hours Min.	. (Month, Day, Yea	r) 9. Birthplace (State or Foreign Country)
	Director		220-26-3884	75	Yrs.	3-20-10	133 MD
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location		10d. Inside City Limits
	Manyl f aho	ō	MD Ware	ester bo	Mideron		1 ♥Yes 2 No
	the t	rect	10e. Street and Number		10f. Zip Code	100.0	Citizen of What Country?
	with Sa or	by Funeral Director	200 Com	norce Stre	et 21863	\	159
	death ms 2	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race - American Indian,
9	after or Ite	Fū	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ahow ta Medical Examinati, and be inclined at		3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ੴ No Specify:		Specify: BIOLCK
5-0	72 h	Completed	15. Decedent's I (Specify only highest g	Education 16 rade completed)	Sa. Decedent's Usual Occupation (Give kind of work done during most of wo	nrking 16b.	Kind of Business/Industry
121	hen hen	du	Elementary/Secondary (0-12)	College (1-4or 5+)	iife. DO NOT use retired)	H	My From
	iled v tygie her t		17 Father's Name (First Middle / as	¢1	HU+Che	ma /First Middle Maide	a Sumamal
anc	be fi	Be	17. Father's Name (First, Middle, Las	Prummon	A Doc	me (First, Middle, Maide	on Sumame)
3	S should be filed with and Mental Hygiene. is marked other that aumatic event, It a	2	Leonard		C NO	each He	A GOOD TO SEE
Maryland			19a. Informant's Name/Relationship	(Type, Print)	9b. Mailing Address (Street and Number or R.	urai Houte Number, City `L	r or lown, State, Zip Code)
	1 and Health am 27 sther tr		20a. Method of Disposition	20b. Place	of Disposition (Name of	Date 20c.	Location - City or Town, State
Baltimore,	Pages nent of int: If it iry or o		1 Burial 2 Cremation 3	☐Removal from State ceme	tery, crematory or other place)		
Ħ	permit. Pag Department Important: I any injury o		' 4 □ Donation 5 □ Other (Spec	TOP! II	22. Name and Address of Facility	P-5008 H	
Ba	permit. Pages Department of Important: If i any injury or one		21. Signature of Funeral Service Lice	4.4.7	Bennie Smith Funer		7 W. Isabella St.
			23a Part 1. Enter the disease, or cor	polications that caused the death. D	o not enter the mode of dying, such as cardia		Approximate
. 8	ja:		shock, or heart failure. List ont Immediate Cause (Final	one cause on each line.	0	o or rospiratory arrost,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Breast Conver		5 months
ÿ	Examiner			Due to (or as a consequence			
10	LAGIHIIIEI				a or).		
	,e	er	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a consequence			
	,e	ımlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.	b. — Due to (or as a consequence			
0,	,e	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	е ођ.		
,092	ite be executed sysician and he burial-transit	ical Examiner	that initiated events	b. Due to (or as a consequence.	е ођ.		
99	ite be executed sysician and he burial-transit	cal	resulting in death) Last	b. Due to (or as a consequence.	е ођ.		
99	ite be executed sysician and he burial-transit	cal	resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	b	ee of):		23d. Date of delivery
. Box 68	ite be executed sysician and he burial-transit	cal	If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \$\sumeq\$ Yes \$2\$ Yes \$2	b. Due to (or as a consequence d	ee of):		23d. Date of delivery Month Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** A M Iris R. Bouchard 26, 2008 10:20 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) San Juan, . Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 k F Months Director 133-22-0645 75 May 10, 1932 Puerto Rico Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9801 Raleigh Tavern Court 20814 U.S.A. Funeral r than "natural", or items the Me Ical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give 1 □ Never Married 2 □ Married 1 DWes 2 □ No Specify: Puerto Rican Specify: White Completed by 3 ☐ Widowed 4 🛣 Divorced Year or Dates 16b. Kind of Business/Industry Inter 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) American Employment Agency 12 President Pages 1 and 2 should be filed nent of Health and Mental Hygi ant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francisco Rivera traumatic <u>Julia R. Nevarez</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ed Bouchard (Son) item 27 other t 1207 N. Harrison St, Arlington, VA 22205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 XRemoval from State permit. Page Department o Important: If any Injury or = 5 5/1/08 Chantilly, Virginia The Cremation Center: 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Murphy Falls Church Funeral Home Signature of Funeral Service Licensee 1102 W. Broad St., Falls Church, VA 22046 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) End Stage Chronic Obstructive Airway Disease Years /Medical Due to (or as a consequence of) Examiner CO2 Retention
Divide (or see a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner physician and the burial-transit CO2 Pulmonale

Due to (or as a consequence of) 83 IF FEMALE: use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month 5 Other (specify) detached 9☐Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 ☐ Yes 2 ☐ No 1 TYes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ٩ 1 Inpatient 2 ☐ ER/Outpatient 3 X DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

10

Maryland 21215-0036

Baltimore,

Records,

Vital

5

Division

Bouchard,

Registrar

29b. Signature and title of certifier

Saima Khawaja, 1 31. Date filed (Month, Day, Year) APR 3. 0 2008

Saima Chomaja

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

11119 Rockville Pike, # 100, Rockville, MD 20852

D0058965

29d. Date signed (Month, Day, Year)

April 26, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G891 5/05/09 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. C. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month May 4^{Day} 200^{Yea} Physician 1:50 Αм Anne Julia Biddison /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Howard Columbia 6819 Caravan Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 30, 1920 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours (Country) 1 M 2 KF 87 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Show r 28a-f show notified at 1 ☐ Yes 2 No Director Columbia MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or United States 21044 6819 Caravan Court Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: ģ White 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle Watkins Walter C. Beadles 2 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (0) : If item 27 is 850 County Road 326 Westcliffe, CO 81252 Marcy J. Berilla/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or Marriottsville, MD Crest Lawn Mem. Gard. 5-6-2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and as the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2 XNo 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy 2□ No certificate 1□ Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2X No 1 Inpatient 2 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours are.

To the Funeral Dir 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 009526 May 5, 2008 10 E.G. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arts Build, Suite 104, Columbia, MD Medical State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2 / 8/8 **Physician** 35 Ann /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Thomas More Nursing Home Hyattsville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day. Year) Days **Funeral** 1**X** M 2 □ F 1/27/1918 Trinidad 579 84 7985 90 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 ☑ No Director DC Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or USA 20012 death v Funeral 6729 Piney Branch Rd NW 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give⁴
Year or Dates: "natural", or items 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ★ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x ☐ No Specify. Specify: Black ò 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural any injury or other traumatic event, the Medical Expone. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Commercial Building Co Construction Worker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Hackshaw Leonard Blake ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6610 Robania Rd Temple Hills, Maryland 29748 Earl Blake/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/30/2008 Alexandria, VA Metropolitan Crem. 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee Washington, DC 20011 4217 9th St Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) trevioscher -one Physician /Medical Due to (or as a consequence of) Examiner Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Decubitus UKOR 2 No 2 No 1∏ Yes Distante 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 TYes 2 No 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

Medical 29a, Certifier (Check only one) within 2 29b. Signature and title of certifier State 0 2008 APR 3 Registrar

29c. License number 0015

29d. Date signed (Month, Day, Year)

APRIL 27 2008

3 Queensburg Rd Hyattsville MD20781 31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month APR 29 WILLIAM HENRY COTTOMS, III 2008 1:35 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1**⊠**M 2□ F Months Days Hours Min. 58 230-60-5612 Usual Residence of Decedent FREDRICK SUICE Va 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 600 22701 Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 71- 96 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: Biscil 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MILITARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship :1/ans- Wife 600 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1⊠Burial 2 □Cremation 3 □Removal from State SPOTOULUANIE, UK 4 Donation 5 Other (Specify) 108 21. Signature of Funeral Service Licensee 22. Name and Address of Facility & Colinson Lennell AIN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE PULMONARY INFILTRATE Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2√ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐Xnpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

permit. Pages 1 and 3 Department of Health Important: if item 27 any injury or other tra once.

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

"natural", or items

7 is marked other than "natu traumatic event, the Medical

Funeral Director

Š

Completed

Be P

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant if Item 27 is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Examine burial-tra physician attending pl director,

Physician/Medical þ Be Completed Medical Certification: To after death | Director: / d in by the f

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, filled within 24 hours a To the Funeral I

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WHITTAKER DAVID R. 31. Date filed (Month, Day, Year)

MAY 0

5 Pending investigation

6 Could not be determined

27. Manner of Death

1 XNatural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

LCDR MC USN

28a. Date of Injury (Month, Day Year)

and manner stated.

29c. License number

M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

0101232175 (VA)

30/2008

NATIONAL NAVAL MEDICAL CENTER

28d. Describe how injury occurred

20889-5600 BETHESDA MD

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

		•	State of Maryland / Dep. 1- State Registrar Ce	artment of Health and M	lental Hygien	21118 ISBS
ì	Physici	_	1. Decedent's Name (First, Middle, Last) Madeleine Therese Carbonaro		2. Date of Death	3. Time of Death
	/Medic Examin	4.0	4a. Facility Name (If not institution, give street and number) 13553 Osprey Lane	4b. City, Town, or Location of Death Dowell	4	4c. County of Death Calvert
*	Funeral Director		5. Social Security Number 578-42-8470 6. Sex 1 M 2 F 7. Age (In yrs. last birthday, 75 Yrs. Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea May 13,	9. Birthplace (State or Foreign Country) 1932 New York
	he Maryland 8a-f ahow outled at	ector	MD Calvert Dowell		10-	10d. Inside City Limits 1 □ Yes 2√2 No
	n with th	ai Dir	13553 Osprey Lane	10f. Zip Code 20629	10g. (Citizen of What Country? USA
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23s or 28s-f ahow appriourned to other traumatic avant. I'm Madical Examination must be notified at anote.	t by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecfly Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	d within 72 ha giene. ir than "natu the Medical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of work DO NOT use retired) Office Manager	ing	Kind of Business/Industry Onstruction
73	should be file nd Mental Hyg marked othe imatic avant,	To Be C	17. Father's Name (First, Middle, Last) Roland Page Fox	18. Mother's Name Madelei	e (First, Middle, Maid Lne	en Sumame) Hodot
Mar	d 2 sho th and I th small traume			ing Address (<i>Street and Number or Rura</i> 33 Oscrey Lane Dov		y or Town, State, Zip Code)
Baltimore,	Pages 1 and 2: ment of Heath a ent: if item 27 is ury or other trau		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Dispository commetery, creations at the commetery, creating the commeters and comments are commented.	osition (Name of matory or other place) May atory 2008	Date 20c.	Location - City or Town, State Clinton, MD
Balt	permit. Depart Import any inj		Mary J. Soff	3125 Southern Mary	land Blvd.	
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	y anteny dis		Approximate Interval Between Onset and Death
	Examiner	e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): Due to (or as a consequence of):			
8760,	sate be executed obysicien and the burial-transit	icai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.			
P.O. Box 68	To the Hospitel or Attending Physicien: The law requires that the deeth certificate be executed within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	ouse contribute to the cause of death?
Division of Vital Records,	icien: The law re certificate has be rector, page 2 sho	Completed			24a. Was an autopsy performed 1 Yes 2	
f Vit	Physicien: The this certificate har all director, page	To Be	25. Was case referred to medicat examiner? 1	Other	me 5 Residence	6 ☐Other (Specify)
sion o	ending Pth eath. or: After thi	Certification:	27. Manner of Death Senatural 5 Pending (Month, Day Year) Accident Investigation	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
<u>S</u>	tel or Att rs after d al Direct ed in by I	Certifi	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea (Check only one) Certifying Physician: To the best of my knowledge, dea (Check only one) Amelical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	red at the time, date a	and place, and due to the cause(s)
)	To T com	2	29b. Signature and title of certifier Joseph J Suffer	29c. License number 500527	22	Date signed (Month, Day, Year) 4/30/08
1RI	W 15		30. Name and address of person who completed cause of death (Item 23a) (Type John Barth MD 110 Hospital Road		MD 20678	8
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 2008 32. Registrate Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Adrii 29, 2008 Physician Lorraine **Ortis** 1:47 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Asbury-Solomons Health Care Center Calvert Solarans 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8, Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Adril 16, ¹1923 1 ☐ M 2 🕱 F North Dakota 85 222-09-6228 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County In than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Virginia Henrico Richmand 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with 918 South Gaskins Road 23238-5905 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No white Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) hammaker own hame permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If then 27 is marked other the any injury or other traumatic event, the jonce. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christian Edwardson Grace Hoffmeyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Katherine Curtis-daughter P.O. Box 383, Upperville, VA 20185 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 05/01/2008 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee P.O. Box 600, Lusby, MD 20657 23a. Part1. Enter the disease, or complications that caused the shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final CONGESTIVE HEART WEEKS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Y FAR CARDIUMTOFAT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the th IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ New 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 A Hursing Home 5 Residence 6 Other (Specify) Hospital: Lo 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: or Attending 1 Natural 5 Pending s after dea... ral Director: Aftr 1 🗌 Yes 2 🗆 No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours a

To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30,2008

DHMH 17 Rev 1/2001

State

Registrar

John/H. Weigel, MD 110 Hospital Road Suite 310, Prince Frederick, MD 20678

32. Registrans Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 2008

31. Date filed (Month, Day, Year)

MAY

State of Maryland / Department of Health and Mental Hygiene

		·	1 - For State Registrar	e or iviaryia		tificate of D			Reg. No.	211118	16041
or.	Physici	an	1. Decedent's Name (First, Middle, Last) Thomas A. Cardinale					2. Date of De Month 5	ath Day	2008	3. Time of Death 12:56 PM
	/Medic		4a. Facility Name (If not institution, give street a.	nd number)		4b. City, Town, or I	Location of Death			County of Death	12.30 1
-			Atlantic General Hosp			Berlin				rcester	
	Funeral Director		5. Social Security Number 213-34-4707 Usual Residence of Decedent		s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da 5/11/19	y, Year)	9. Birth	place (State or Foreign ntry) MD
	yland yland at		10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	e Mar ta-f sh tifled	Director	MD Worcester	Be	erlin						1 □Yes 2□No
	with th	Dire	10e. Street and Number			10f. Zip Code	1			en of What Cou	ntry?
	ns 23	Funeral		s Decedent Ever in	U.S. 13.	2181 Nas Decedent of His f Yes, specity Cubar		ecity Yes or No		USA 4. Race - Ameri	
936	be filed within 72 hours after death with the Maryland ttal Hyglene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☑ Married 1 ☑ If You	ned Forces? Yes 2		f Yes, specity Cubar 1 □ Yes 2 🛛 No		Hican, etc.)		Black, White, Specify: whi	
Maryland 21215-0036	72 ho "natur adical	Completed	15. Decedent's Education (Specify only highest grade comp	leted)	(Give	dent's Usual Occupa kind of work done do DO NOT use retired)	urina most of work	ing	16b. Kin	d of Business/Ir	dustry
7121	within liene.	dwo	Elementary/Secondary (0-12) Col	ege (1-4or 5+)		eacher			Edu	cation	
nd	be filed tal Hygi d other event, tl	BeC	17. Father's Name (First, Middle, Last)		'		18. Mother's Name			Surname)	
yla	2 should be and Menta is marked aumatic ev	٦ ح	Anthony Cardinale	-41	40h Maillin	ng Address (Street a	Theresa			Town Chata 7	- Codel
<u>B</u>	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type. Prin Mary Kay Cardinale /		1	Ann Court				rown, State, Zi	o code)
Baltimore,	Pages 1 and 3 nent of Health int: If Item 27 ary or other tr.		20a. Method of Disposition 1 □ Purial 2 □ Cremation 3 □ Remova	i from State	Place of Dispo cemetery, crei	sition (Name of natory or other place	e) [Date	20c. Loc	cation - City or T	
	# 된번 등		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	5		Memorial P		/2008		nkford, uneral	
ä	Depa Impo any i		Kim Mac	Recol		108 Wil	liam St.	, Berli	in, M		TOILLE
			23a. Part . Enter the disease, or complications shock, or heart failure. List only one caus					or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			ery Diseas	e				6 years
Į.	Examiner			ue to (or as a conse	equence or):						
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a conse	equence of):						
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68760,	ificate be executed g physician and as the burial-transit	calE	d	, ,							
	‡ മെജ	Wedical	IF FEMALE:								
Box	The law requires that the death cert te has been signed by the attending tage 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	es, outcome pf preg Live birth 2□Fe Pregnant at time of Unknown	etal death 3	Ectopic pregnancy Other (specify)			2	3d. Date of deliv	very Day Year
P.0	that the de led by the a detached i		9 ☐ Unknown Part II. Other significant conditions contributin		esulting in the u	nderlying cause give	n in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
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Records,	aw requir s been si 2 should I	Completed						24a. Was		24b. Were aut	opsy findings available
ž		Som						auto perf 1∐ Yes	ormed?	death?	
or Vital	Physiclan: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?			ot 3CLDOA Othe	26. Place of Deat				
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0	Attending Phrdeath. ector: After the by the funeral	ation	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work	? /es 2 □ No				
Division	al or Atter after dea I Directo	Certification:	3 Suicide 6 Could not be determined 28e	Place of injury - At building, etc. <i>(Spec</i>	home, farm, str cify)	eet, factory, office		28f. Location (City or To	(Street and wn, State)	d Number or Ru	ral Route Number,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Check only one) 29a. Certifying Physician: 29a. Certifier 2 Medical Examiner: One an								
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number		29d. Date	e signed (Month	, Day, Year)
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P	Abri		30. Name and address of person who complete	/	2 .	. 1	P . 11	44.0	COLL		
2	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	n Revail	Berun,	ru 21	X 1)		
	Regist		**** 0 E 2008	La .	H	(nach)					

William G. CharmAR

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		•	1 - State Registrar			Certificate of	Deatl	7	Reg. No.	2008	LIGHT
		3.	1. Decedent's Name (First, Middle, Las					2. Date of D	eath Day	Year	3. Time of Death
	Physici /Medic		William G. Charma	ık				05	0a "	D8 Year	4.25PM
	Examin		4a. Facility Name (If not institution, give	ic of the	LAK	4b. City, Town, o	bus	4	u	ounty of Death	ico
8	Funeral Director		5. Social Security Number 6/S: 115-30-7815		In yrs. Iast bir 59	thday) If Under 1 Year Months Days	Hours	er 24 Hrs. 8. Date of Bi (Month, D 6/19/1	rth a <i>y, Year)</i> 938	9. Birth	hplace (State or Foreign untry)
	p .		Usual Residence of Decedent		0- Oit T						10d, Inside City Limits
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Ŀ		llier	0c. City, Towr		M	n=1.ca			1 □ Yes 2X No
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	with the a or 2	Funeral Director	6770 Beach Resort	Dr. Apt.1	3	10f. Zip Code		34114		SA	unity:
	s 232	eral	21 / Marrara Dr.	12. Was Decedent Eve	rin II S	13 Was Decedent of F	lisnanic (SA 4. Race - Ame	rican Indian,
	Item Iner	Ë	11. Marital Status 1 ☐ Never Married 2[X] Married	Armed Forces? 1 ☐ Yes 2 ☐ XNo	7 111 0.0.			Origin? (Specify Yes or Nean, Puerto Rican, etc.)		Black, White	e, etc.
39	al", or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specif	y:	S	Specify: W	nite
21215-0036	2 hou	ted	15. Decedent's Ed		16a.	Decedent's Usual Occup	ation	act of working	16b. Kind	of Business/	Industry
215	e. an "n Medi	ed l	(Specify only highest gra	College (1-4or 5+)		(Give kind of work done life. DO NOT use retire		DSI OF WORKING		_	
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yla	Meni arke	ျ	Henry Charmak					herine Halu			
Maryland	2 sh and Ism raum		19a. Informant's Name/Relationship (. Mailing Address (Street					
o,	1 and Healti		Barbara Charmak /			A Mallard Disposition (Name of		Date		ation - City or	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifled at once.		1 ☐ Burial 2 💆 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removar from State	Cape I	Disposition (Name of ry, crematory or other pla Henlopen Cre	ce) em.	5/5/2008		nkford,	
alti	Departm Departm Importal any Inju		21. Signature of Funeral Service Licer		1	22. Name and Addre		THE DUI			1 Home
	20 E # 9		Just 7	mil	- death Da			t., Berlin,		1811	Approximate
			23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do	not enter the mode of dyl	ng, such	as cardiac or respiratory	arrest,	fm .	Approximate Interval Between Onset and Death
1	Physician / Medical		Immediate Cause (Final disease or condition resulting in death)	a Bladd		reinoma &	with	Metestasia	to Kee	loxes?	
	Examiner			Due to (or as a c	consequence	of):					
	480	<u>ا</u>	Sequentially list conditions. if any, leading to immediate	b. Due to (or as a c	consequence	of).					<u> </u>
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
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Box	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf 1 Live birth 2		n 3 □Ectopic pregnanc	:y		23	3d. Date of del Month	livery Day Year
	e dea the at ned fo	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	ne of death	5 ☐ Other (specify) _				World	Day Tour
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lon	Attending Phrdeath. ector: After the type the funeral	ţi	1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day \	rear)		rk?]Yes 2	□No			
Division	Attend r death. ector: / by the f	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc.	- At home, fa	arm, street, factory, office			(Street and	Number or R	Rural Route Number,
Ö	s afte al Dire	Certification:	- LITOLIIOUG	banang, etc.	(5000)			0.13 01 1	, •)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ledical (29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example (Check only one)	nysiclan: To the best of miner: On the basis of e and manner state	xamination ar	e, death occurred at the t nd/or investigation, in my	ime, date opinion,	and place, and due to the death occurred at the time	e cause(s) e, date and	and manner a place, and du	s stated. le to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	2 2		29c. Licen	se numbe	er	29d. Date	signed (Mon	th, Day, Year)
			Marson 9	4 Bol	12-5	En D2	295	05	^	5 - 0	3-08
			30. Name and address of person who	completed cause of dea	th (Item 23a)						
B	A8		GREGORIO M.			:5302 CHI	NABE	ERRY DR., S	ALISB	URY, N	10 21801
40	Sta		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	Acoste)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last **Physician** 28 OF /Medical 4c. County of De a. Facility Name (If not institution, give Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 **Y**M 2□ F 213-24-123 April 25, 1932 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County or items 23a or 28a-f show 1 Yes 2 No Balt more permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U 5 A 2206 Avenue ROSIYN Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Eves 2 □ No 1951 If Yes, Give Year or Dates: 1953 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: þ Black 3 ☐ Widowed 4 1 Divorced 1954 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Defense College (1-4or 5+) Elementary/Secondary (0-12) contractor Telecommunications tech. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Crawley ပ္ 196. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Apt. 2- Washington, D.C. 20009

Date 20c. Location - City or Jown, State Chambers Damara Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Veteran's 22. Name and Address of Facility
HENRY FUNERAL HOME, P.A.
SIO Washington St. Cambridge 21. Signature of Funeral Service Licensee MD. 21613 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) respiratory distress syndrome week Physician /Medical Due to (or as a consequence of): Examiner reumonit Sequentially for conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed cancer un a burial-tran Due to (or as consequence of): Box 68760 attending physician Physician/Medical as the t asn 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 2 1 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one director. Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA ပို completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After it (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P21202 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Bernard

DHMH 17 Rev 1/2001

MD

10 N. Greene Street.

Baltimose

State of Maryland / Department of Health and Mental Hygiene 👂 🕦 🥱 Cottificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** <u>0</u>4:50 A^M 4/30/2008 JACKSON ROSSE COLLINS, JR. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** KENT CHESTER RIVER HOSPITAL CENTER CHESTERTOWN Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1**X** M 2 □ F 6/28/1934 NY 73 Director 220-32-9192 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County show other than "natural", or Items 23a or 28a-f shovent, the Medical Examiner must be notified at 1XYes 2□No Director QUEEN ANNE'S CENTREVILLE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21617 USA 325 ROLLING BRIDGE RD. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Examiner must Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X es 2 No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: ş Year or Dates:1957-1963 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ACCOUNTING ACCOUNTANT 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELIZABETH BODINE JACKSON ROSSE COLLINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 325 ROLLING BRIDGE RD. CENTREVILLE, MD 21617 THERESE C. COLLINS/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) CENTREVILLE, MARYLAND CHESTERFIELD CEMETERY 5-4-2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oncet and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 2 ER/Outpatient 3 DOA 1 🗌 Yes 1 Inpatient Certification: To After this 28b. Time of 28d. Describe how injury occurred 27. Map ler of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 1 🗖 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) Signature and title of Name and address of person who completed cause of death (Item 23a) (Type, Print) ShanahanMD onth, Day, egistrar's Signature Year) State 0 1 Registrar

			For 1 _ State	State	of Marylan		artment of H		d Mental Hy	/giene	
			Registrar	N- 1 4\		Cel	rtificate of	Death	2 Date of D	Reg. No.	8,46044
193	Physici	an	Decedent's Name (First, Midd	le, Last)					2. Date of D Month	Day Ye	
45	/Medic			Frances		Dent			April		
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100			Larkin Chase Ha 5. Social Security Number	rborside 6. Sex	Nursing 7. Age (In yrs.		Bowie If Under 1 Year	If Under 24 H	Hrs. 8. Date of B		Birthplace (State or Foreign
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1.54	Director		579-36-4909 Usual Residence of Decedent			91 115.			April	5, 1917	Mellwood, MD
	land ow		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
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	the 28a	Director	10e. Street and Number	e George	5 I	OLESLY	10f. Zip Code			10g. Citizen of Wha	t Country?
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	TIS 2	Funeral	11. Marital Status	12. Was De	cedent Ever in U	I.S. 13.	Was Decedent of H If Yes, specify Cuba		(Specify Yes or N		American Indian,
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<u>la</u>	Ment Ment arked attc e	၉	Richard Natha	niel Bats	on			Rose	Hawkins		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hylgene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other treumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relation	ship (Type. Print)			•			ber, City or Town, Sta	
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Baltimore,	of Hiter	•	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from		Place of Dispo cemetery, crea	osition (Name of matory or other plac	ce)	Date	20c. Location - City	y or Town, State
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at	permit. Departi Imports any inj once.		21. Signature of Funeral Service	Licensee	,	2	2. Name and Addre	ss of Facility 1	AcGuire F	uneral Ser	vice, Inc.
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	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Medical	29b. Signature and title of centif		anner stated.		29c. Licens	se number		29d. Date signed (/	Month, Day, Year)
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			30. Name and address of persons 9500 Annapoli					06 Rich	nard I I	'eldman M	n.
	Sta	ate	31. Date filed (Month, Day, Yea	r) /	. Registrar's Sign		III 201	JO KICI	L . C Dane	Chamail II	
В	Regist		MAY 0 2		de de		S.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend 23a, 24a-b, 27, 28a-f, per Fort 887 8/71/48 TT Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Armando V. Fernandez 5:35 A M April 26 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hosp: fal of Sina: Bultimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 → M 2 □ F Months Days Hours Min. 219-72-6335 48 Director March 29, 1960 New York Usual Residence of Decedent death with the Maryland 10c. City. Town or Location a or 28a-f show t be notified at 10a State 10b County 10d. Inside City Limits 1 Yes 2 □ No Directo Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a on the must be 5008 53rd Place 20781 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Puerto Rican 1
☑ Yes 2□ No þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than vent, the Me Elementary/Secondary (0-12) College (1-4or 5+) Clerk Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Fernandez, Sr. Zaida Rivera ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Zaida Zanata 5008 53rd Place, Hyattsville, MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 5/1/2008 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Head and neck injuries with complications** Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Asperation disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury STATE OF THE PROPERTY EXMANES Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and is the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1X Yes 1 XYes 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1X) Yes 27 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P this ours after death.

neral Director: After this filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 -5 Pending investigation Feb. 22, 200810:15 A^M 1 ☐ Yes 2 🙀 No 2 Accident subject assaulted 6 ☐ Could not be 3 Suicide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Roxbury Correctional determined Detention Center Inst. Hagerstown, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760,

21215-0036

Maryland

Baltimore,

t

State Registrar

MAY 0 1 2008 DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hans

MD

29c. License number

D59062

29d. Date signed (Month, Day, Year)

Apr: 1 26 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Y April 30, 2008 Year 12:12 a James Henry Foley, Jr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Takoma Park Montgomery Washington Adventist Hospital 8. Date of Birth (Month, Day, Yea Nov. 29, If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex Year) Days 1 X M 2 T F Virginia 1936 223-40-8276 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Prince George's Adelphi Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20783 10413 Floral Drive Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify White Year or Dates: 1954-56 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Golf Instructor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nellie Leona Gordon James Henry Foley, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10413 Floral Drive, Adelphi, MD 20783 Mary Ann Foley/Wife May Date 5. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 2008 4 Donation 5 Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS DAYS disease or condition resulting in death) Due to (or as a consequence of): ASPIRATION Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) 4☐Pregnant at time of death 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical **Examiner**

The law requires that the death certificate be executed

Records, P.O. Box 68760.

Division or Vital

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, p

To the Hospital or Atte within 24 hours after der To the Funeral Directo completely filled in by the

Examiner

Physician/Medical

þ

Be Completed

Certification: To

Medical

Physician

/Medical

Examiner

10a. State

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must

Baltimore. Maryland 21215-0036

Director

Funeral

þ

Completed

Be (

with the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 TUnknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STATUS POST COPONARY

MEDICATION

24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical examiner? 1 Tes 2 No 27. Manner of Death 1 Natural

CHRONIC

5 ☐ Pending investigation

28a. Date of Injury (Month, Day Year)

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

4 Homicide 29a. Certifier

2 Accident

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier MUS

29c. License number D36207 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas C. Militano, MD

6 Could not be determined

7610 Carroll Avenue, #440, Takoma Park, MD 20912

State Registrar

11

31. Date filed (Month, Day, Year) MAY 0 2 2008



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2308 Gruver Apri スな 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ef - MOV None University If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) vrs. last birthday) 5. Social Security Number 6. Sex Age (In **Funeral** Days Months Hours 1**X** M 2□ F Yrs April 1929 Washington DC 79 577 34 6070 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show at 1 ☐ Yes 2 No a or 28a-f sho t be notified a Director Ellicott City Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 2649 Turf Valley Rd 21042 Items 23a r than "natural", or Items 23a the Medical Examiner must Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 □ X es 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. e filed within 72 hours after de la Hygiene. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: White 3X Widowed 4 □ Divorced Year or Dates: 1951-53 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Electric Energy Consultant 5+ and Mental Hygivis Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Olive Bagby John H. Gruver ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2649 Turf Valley Rd Ellicott City, MD 21042 John G. Gruver/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 5-3-2008 Ellicott City, MD St. Johns Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 Deni Ollis-4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications if at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Carol Halbar we Examiner Su. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner CHATTENATURE APPROVED BY MEDICAL EXAMINE The law requires that the death certificate be executed burial-trai Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) signed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ▼ No 24a. Was an certificate has the irector, page 2 s autopsy performed? Yes 22 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 📉 No tall Standing pril 28,2008 1200 trom 2 Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) 3 ☐ Suicide 4 Homicide Southern States Seed Ellicott City, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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EG.

Timothy dam

MAY 0 5 2008

29b. Signature and title of cortifier

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

VA 0101242845

Bultimore, MD

fless of person who completed cause of death (Item 23a) (Type, Print)

22 South Green

21201

State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2008 ${\tt A}^{\sf M}$ May 11:00 William E. Gable /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ellicott City 9820 Old Annapolis Road Howard If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**∑**M 2□F Yrs. 79 May 10, 1928 Director 264 42 3519 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f shovidical Examiner must be notifiled at 1 ☐ Yes 2 TNo Director MD Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9820 Old Annapolis Road 21042 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 R Yes 2 No If Yes, Give Year or Dates: 1946–48 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupatio 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. the <u>Civil Engineer</u> Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental h and Mental William C. Gable Carrie Smith Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a :: If Item 27 Is / or other tra 9820 Old Annapolis Road Ellicott City, MD 21042 Jean K. Gable/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Crest Lawn Mem Gard. 5-6-2008 Marriottsville, MD 4 Donation 5 Other (Specifyentombment 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 (4 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician eso the disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last certificate be executed and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No o. the detached 9□Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an has autopsy The performed? this certificate 1X Yes 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Standard 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Knight 11065 Little Patuxent Pkwy Columbia, MD 21044 MAY 05 31. Date filed (Month, 32. Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAY 05

2008

BA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Glenn Arzadon. 4714 Health wy Drive Born MD 21811

32. Registrar's Signature

The law requires that the death certificate be executed

	Please	Type or Print	in Black Indelible Ink. Ensu	re All Copies	Are L	egible.
	For	State of Mar	yland / Department of Health a	and Mental Hyg	giene	
	1 - State Registrar		Certificate of Death	R	leg. No.	200
	1. Decedent's Name (First, Middle, La	st)		2. Date of Dea	ıth	
Physician /Medical	Frances	Caro1	Gillette	Month May	Day 9	Year 2008
Examiner	4a. Facility Name (If not institution, giv	e street and number)	4b. City, Town, or Location of	f Death	4c. C	ounty of De

	Reg	J. No.	.0			8	į	6. 1	1	7
1	2. Date of Death	D	**	-		Topic	3. Tim	e of D	éati	h
	Month May	Day 9			Year 008		135	5	P	M
	•	4c. (Cour	ity o	f De	ath				

White

23d. Date of delivery

Day

2 No

Year

Month

Name (If not institution, give street and number) 4b. City. Town, or Location of Death

Ceci1 E1kton 103 Danford Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 M 2 X F Yrs Dec. 30, 1940 Washington, D.C. 213-38-3176 67

Usual Residence of Decedent

Funeral

Director

iral", or Items 23a or 28a-f show Examiner must be notified at

"natural"

permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any Injury or other traumatic event, the Medical

Physician

/Medical

Examiner

and

nding physician

been signed by the should be detached

this certificate

After

after death filled in by the

within 24 hours a

or Attending Physician:

use as the burial-tran

Baltimore,

Funeral

Completed by

Be

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Examiner

Physician/Medical

Completed by

Be

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Certification:

Medical

the Maryland

death with

72 hours after

10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Maryland Cecil Directo E1kton

10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Danford Drive 21921 United States 14. Race - American Indian, 11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced

16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) In her own home

12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Thomas Clagett Genieva Mullican 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Thomas Gillette/Husband 103 Danford Drive, Elkton, MD 21921

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State

R.A. Ferris & Co., INC: May 14, 2008 West Chester, PA 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD 21921 Approximate Interval Between Onset and Death

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final

disease or condition resulting in death) Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No perform 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital:

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Magner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type

32. Resstrar's Signature 31. Date filed (Month, Day, Year) MAY 16 2008

Registrar DHMH 17 Rev 1/2001

State

		_	For State Registrar	State o	of Maryla	and / Dep	artment ertificate			ınd M		giene Reg. No. 9	008	16	051
-		9	Decedent's Name (First, Middle	, Last)							2. Date of Dea	ath	UUU	3. Time of	Death
	Physicia	_	Marion	Delores	Harris	5					April 28	, 2008	Year	10:15F	М
	/Medic Examin	~~	4a. Facility Name (If not institution	, give street and nι	umber)		4b. City, 7	Town, or	Location of	f Death			nty of Death		
			3940 Bexley Place #		T		Suitla		If I lades 6	2411=0			e Georg		E
	Funeral		5. Social Security Number 579–48–2875	6. Sex 1 ☐ M 2 💢 F	7. Age (In y	rs. last birthday Yrs.	/ If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day Dec. 0,	n 19 ³ 7	WAShi	place (State on ntry) ngton, D	r Foreign
4	Director		Usual Residence of Decedent		13						DCC.0, 3		14 154 22	,	
	/land ow at		10a. State 10b. County		10c.	City, Town or I	ocation							I 0d. Inside Ci	-
	Many a-f sh ffied	to	Maryland Prince (le orge	5	Suitland								1 ☐ Yes	2. No
	or 282	Directo	10e. Street and Number				10f. Zip					-	of What Cou	ntry?	
	23a cust b	ral	3940 Bexley Place					746				USA			
	tems	Funeral	11. Marital Status	I Armed F	cedent Ever in orces?	n U.S. 13	. Was Deced If Yes, spec	ent of Hi ify Cuba	ispanic Orig ın, Mexican	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	1	Race - Ameri Black, White,	etc.	
30	rs afte	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🗓 Divorced	ed If Yes, G	2 No Sive X No Dates:		1 ☐ Yes 2	2∭ No	Specify:			Spe	ecity: Blac	k	
9500-61212	n 72 hours after death with the Marylar "natural", or items 23a or 28a-f show adical Examiner must be notified at	ed	15. Deceden	t's Education		16a. Dec	edent's Usua	l Occupa	ation		- 1	16b. Kind o	f Business/In	dustry	
212	hin 72 In "na Media	plet	(Specify only higher Elementary/Secondary (0-12)		(1-4or 5+)	(Gin	e kind of wor DO NOT us	k done d e retired	during most l)	t ot worki	ng				
7	ygiene rgiene er the	Completed	12			Secre	tary					Health			
Maryland	I be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle,	Last)							(First, Middle,	Maiden Sur	name)		
<u>\ </u>	Men Jarke Jarke	2	Thurston McNeil	hin (Time Driet)		10h 84n	ling Address	(Street	Ethel		11iams al Route Numbe	er City or To	wn State Zi	n Code)	
<u>g</u>	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relations Marion H. Norman/								ham, Md.		m, otato, zi	3 0000)	
a)	tem 2		20a. Method of Disposition	Zagricer	20	b. Place of Dis					Date		on - City or T	own, State	
<u></u>	Pages ent of nt: If i		1 ☐ Burial 2 【X Cremation 4 ☐ Donation 5 ☐ Other (S			Kalas Cre		iner plac	4	1/29/2	2008	Edgewate	er, Mary	oland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur any Injury or other traumatic event, the Medical once.		21. Signatur Funeral Service				22. Name an	d Addres	ss of Facilit	y Geor	rge P. Ka	las Fund	eral Hor	ne	
n	an an an	1.13	Sylf. Ka	(1) A)							Hill, Md				
			23a. Part. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the cach line.	leath. Do not e	nter the mod	e of dyin	ig, such as	cardiac	or respiratory a	rrest,		Approxima Interval Be Onset and	te tween Death
	Physician		Immediate Cause (Final disease or condition	_a S	e12	Ure.	01501	RDE	R				- 8		
	/Medical Examiner		resulting in death)	Due to	o (or as a con	sequence of):									
185		-	Sequentially list conditions, if any, leading to immediate	b	o (or as a con	sequence of):									
	uted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	S											
<u>_</u>	execuin and ial-tra	Еха	resulting in death) Last	Due to	o (or as a con	sequence of):									
760,	death certificate be executed e attending physician and d for use as the burial-transit	ical		d											
89	leath certificat attending phy i for use as th	Med	IF FEMALE:	1			-								
Box	ath ce ttendi or use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	outcome pf pro birth 2 1	Fetal death	B Ectopic pr		/			23d.	Date of deliver Month	very Day	Year
<u>.</u>	at the de by the a tached f	ysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	9□Unk	gnant at time known	of death :	5 ☐ Other (sp	ecrry)							
2	The law requires that the te has been signed by the bage 2 should be detache		Part II. Other significant conditi	ons contributing to	death but not	resulting in the	underlying c	ause giv	en in Part I	١.	23e. Did 1	obacco use	contribute to	the cause of	death?
g	w requires that been signed b should be deta	d by	Demen	Tra							10	Yes 2□N	lo 3□Pro	bably 4	Unknown
Records,	s been shou	Completed	Huper	Tension	J						24a. Was		4b. Were au	opsy findings	available
	: The law cate has I page 2 s	omp	Dicharo	5 Tuni	02						auto perfo 1□ Yes	ormed? 221No	death? 1 ☐ Yes	2□No	Jause of
Vital	(0 14	Be C	25. Was case referred to medica examiner?	1 900						e of Deat	h (Check only				
	hysic his ce I direc	To	1 Yes 2 No			2 ER/Outpat			4 L N	ursing Ho	me 5 Res			rify)	
Ē	Ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	ng (Mo	te of Injury onth, Day Yea	28b. Time Injur		28c. Injur Wor	ryat ′k? Yes 2 □	INO	28d. Describe	how injury or	ccurred		
Division or	death stor: /	icati	2 Accident investi 3 Suicide 6 Could	not be 280 Plac	ce of injury -	At home, farm,			163 2 🗆	110	28f. Location (Street and N	lumber or Ru	ral Route Nu	mber,
2	lor A after Direction by	Certification:	4 ☐ Homicide determ	lined buil	lding, etc. (Sp	pecify)		,,			City or Tò				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 Certifyi	ng Physician: To the	he best of my	knowledge, de	ath occurred	at the ti	me, date a	nd place,	and due to the	cause(s) an	d manner as	stated.	(e)
	he Ho in 24 he Fu pletel	Medical	one)		anner stated.	mination and/or				am occui	red at the time				(9)
	To the within 7 To the comple	Σ	29b. Signature and title of certifie	1 1	1/201	1 4.0			se number	~		29d. Date s	igned (Month	n, Day, Year)	
•			· Celylla			MD		15	034.	Y_		4/1	7/01		
1	(3)		30. Name and ad los of person Crystal Yeldell, M	who comcleted ca .D. 5100 At	use of death ith Way	(Item 23a) (Typ Suitland	e, Print) , Md. 20	746				/	/		
	Sta	ite	31. Date filed (Month, Day, Year,											<u> </u>	
	Regist		APR 3 0 2008	Street	1.15	Signature	,								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1230 P M J. Hollis 2008 Fred May /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ceci1 E1kton 248 Brick Hill Road If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 222-01-5436 Delaware 1916 91 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 shov any injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Summerland Key Monroe Florida 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 33042 United States 1065 Flagship Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1943-46 Specify þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Realtor/Developer Real Estate 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jennie S. Foard Frederick H. Hollis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Steven A. Henderson/son-in-law 248 Brick Hill Road, Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2008 1 Burial 2 Cremation West Chester, PA R.A. Ferris, & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardishook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospitai or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 page 2 s Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only on son-in-law son-in-law residence Other: 4 Nursing Home 5 Residence ≥ No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? After t Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

Funeral Director: A sletely filled in by the fi 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29d. Date signed (Month, Day, Year) nd/title of certifier 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 111 Gloria Simonson, W. High St., Suite 302, Elkton, MD 21921 32 Redistrar's Signature 31. Date filed (Month, Day, Year) State MAY 16 2008 Registrar

3+\ DHMH 17 Rev 1/2001

Die

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Phy G879 5/16/08 JH Registrar amend #1 per Phy G879 5/16/08 JH Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 27,2008 Month **Physician** 7:49A Ellen Jennings April laude /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Longview Nursing Home Manchester Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months Days Hours Min. Director January14,1928 Virginia 80 226-46-1887 the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Carroll Directo Maryland Manchester 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant! I flem 27 15 marked other than "natural", or items 23a or item 23a or or or other thaumatic event, the Medical Examiner must be to uny or other traumatic event, the Medical Examiner must be to U.S.A. Funeral <u>3332 Main Street</u> 21102 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White à 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembler Black&Decker 1.1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Parks Lilly Grigsby ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Shriver /Daughter 2504Foxtail_Road, Hampstead, Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MaudeAddingtonCem. 5-1-08 Nicklesville, Virginia 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service Licensee michael 1400 July 6009Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEARI ALLUM STACTE GESTIVE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Fo the Hospital or Attending Physician: The law requires that the death certificate be executed attending phystcian and for use as the burial-tra Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Injury ₩Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death | Director: | d in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

Division or Vital Records, P.O. Box 68760

within 24 hours aft

To the Funeral DI

completely filled in

29b. Signature and title of certifier evelu

29c. License number 28595 29d. Date signed (Month, Day, Year)

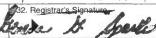
30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

SUITE 203, BALTO MI) 21209 2835 AVHANI AVE, 31. Date filed (Month, Day, Year)

State Registrar

MAY 1 6 2008



			For State		State o	f Marylar				lealth Death			•	000	0.0	LCOTI
			Registrar	o /First Middle I on	1		Ce	runca	te or i	Deam	-	2. Date of De	Reg. No	<u> </u>	15	3 Time of Death
	Physici	an	1. Decedent's Nam	e (First, Middle, Las								Month	Da		ear	Time of Death
4	/Medic		Ianthe	Α.		Jackson		1 0 00		. 1		April		5, 200		2:30 P ^M
)	Examir	er	,	If not institution, give		,				r Location				. County of		
	-		5. Social Security N	o Avenue		7. Age (In yrs.	last hirthday		ver S er 1 Year	pring If Under		8. Date of Bir		ontgo		ace (State or Foreign
	Funeral		579-48-6		х]м 2 X ДF	7. Age (in yrs.	Yrs.	Months		Hours	Min.	(Month, Da	ay, Year)	Count	ry)
	Director		Usual Residence of	f Decedent	H					L		10-30-	1931	B1	cook	lyn, NY
	and w		10a. State	10b. County		10c. Ci	ty, Town or Lo	ocation							10	Od. Inside City Limits
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	the l	Director	10e. Street and Nu				-		ip Code				10g. Ci	tizen of Wha	t Count	try?
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	ier de Item ner i	Ë	11. Marital Status	ried 2 🔀 Married	Armed Fo	rces?	.5.	If Yes, sp	ecify Cuba	an, Mexica	n, Puerto	Rican, etc.)	-		White, e	
36	rs aff	by F	3 ☐ Widowed		If Yes, Giv Year or D	/e		1 🗆 Yes	2 X No	Specify	:			Specify:	B1a	.ck
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show tht, the Medical Examiner must be notified at	ed		15. Decedent's Edi			16a. Dece	dent's Us	ual Occup	ation			16b. k	Kind of Busin	ess/Ind	ustrv
5	n 72 t "na ledic	Set		cify only highest grad	le completed)		(Give	kind of w		during mo:	st of work	ing				,
12	with ene. thar	Completed	Elementary/Seco	ondary (0-12)	College (1	-4or 5+)	Socia	l Sei	rvice	s Rep	prese	native	Fe	deral	Gov	ernment
	Hyginther Hyginther Sint, t		17. Father's Name	(First, Middle, Last)		•				18. Moth	er's Name	(First, Middle	, Maidei	n Surname)		
an	d be ental ced o	o Be	James A	Haddocks						Augu	ısta	(Unknow	wn)			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.	မ	19a Informant's N	ame/Relationship (T	voe. Print)		19b. Maili	na Addres	ss (Street	and Numb	er or Run	al Route Numb	ner City	or Town Str	ate Zin	Code)
<u>≅</u>	d 2 s th ar 7 is trau			. Jackson		and)		-	o Ave			Spring	-			
	1 and 1 Health em 27		20a, Method of Dis		(20b.	Place of Dispo	osition (Na	ame of	1		Date		ocation - Cit		wn. State
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Baltimore,	permit. Pag Department Important: I any Injury o			5 ☐ Other (Specify		Fo	rt Lin					-2008		entwo		
3al	permit. Departr Importa any Inju		21. Signature of Fi	uneral Service Licens	see		I					rt Line				
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Box	The law requires that the death certific the has been signed by the attending prage 2 should be detached for use as	Physician/M	IF FEMALE; 23b. Was deceden	it pregnant	23c. If yes, out	come pf pregn irth 2□Feta	ancy	Teatonia	pregnancy	,				23d. Date of	of delive	ry
	deat e atte	icia	in the past 12 1 ☐ Yes 2 l	months?	4☐Pregr	ant at time of		Other (,				Month	1	Day Year
P.0	at the de by the a tached	hys	9 ☐ Unknown		9□ Unkno	own										
	s tha		Part II. Other signi	ficant conditions of	ntributing to de	eath but not res	ulting in the u	ınderlying	cause giv	en in Part	l.	23e. Did	tobacco	use contribu	ute to th	e cause of death?
Records,	quires n signe ald be	Completed by	Diabet	es, Hyper	tension		<u> </u>					1 🗆	Yes 2	2[X No 3	Prob	ably 4 □Unknown
00	w require been signal	lete										24a, Was	s an	24b. We	re autor	osy findings available
Be	helav shas ge 2:	티										auto perf	psy ormed?	prio dea	or to con ith?	npletion of cause of
Vital			OF W									1□ Yes	2 X N	o 1□	Yes	2 □ No
<u>\frac{1}{2}</u>	Physiclan: r this certific ral director,	Be	25. Was case reference examiner?	<u> </u>	Hospital:		NED/O:		Oth	er:		n (Check only				
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Division	Attending r death. ector: After by the fune	Certification:	2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not be	290 Place	of injury - At h	ome farm et			168 2		20f Location	/Ctm at a	and Museumbar	o v Dum	I Doute Number
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ALHAJI UMAR JALLOH APRIL 25 2008 6:58 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GEORGE'S HOSPITAL PRINCE GEORGE'S PRINCE CHEVERLY 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours Min 1 ☑ M 2 ☐ F Director JUNE 23 1949 SIERRA 579-47**-**8057 58 LEONE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experimen must be notified at Director PRINCE GEORGE'S HYATTSVILLE 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 5325 CHEASPEAKE ROAD 20781 SIERRA LEONE W.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 72 hours after 1 ☐ Never Married 2 ☐ Married BLACK Maryland 21215-0036 1 ☐ Yes 2 🛱 No ۵ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) J be filed within 7 antal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE ENTREPRENEUR yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be find and Mental Find I is marked of MADINATU JALLOH MOHAMMED JALLOH ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zip Code), 6325 LANDOVER ROAD # 102 CHEVERLY, MARYLAND 20705 permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traum JALLOH/DAUGHTER MADINATU Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/4/2008 ADELPHI, MARYLAND GEORGE WASHINGTON CEME. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Ma 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one caul Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician disease or condition resulting in death) /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine be executed burial-tran that initiated events resulting in death) Last Box 68760. physician Physician/Medical certificate the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death requires that the death 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 5 Other (specify) Ö the 1 ☐Yes 2 ☐ No 9 Unknown þ ď. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? aw 24a. Was an has e 2 s autopsy page; The perform certificate 1 ☐ Yes 2 ₺ No Division of Vital 1 ☐ Yes 2 or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 4 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA After this Inpatient Certification: To ate of Injury Month, Day, Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. Accident 1 ☐ Yes 2 🗆 No I Director: A 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 \(\text{Homicide} \) To the Hospital o within 24 hours aff To the Funeral Di filled 29a. Certifier 🗜 🔁 tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely On the sass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title certif

State Registrar

3. Time of Death

Funeral Director 28a-f show ns 23a or 28a-f sh must be notified or items 23a within 72 hours after 21215-0036 than Pages 1 and 2 should be filed the propert of Health and Mental Hygin is marked other Maryland item 27

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Baltimore,

Physician /Medical Examiner

attending physician for use as the huria certificate this After To the Hospital or Attend within 24 hours after death To the Funeral Director:

The law requires that the death certificate be executed

Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760.

Physician Catherine L. Jenkins 2008 APRIL 30 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner harles 8. Date of Birth (Month, Day, Year) If Under 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In vrs. last birthday Days 1 □ M 2 X F Months Hours 217-34-0915 72 May 11,1935 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6440 Port Tobacco Road 20646 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify White Specify: <u>م</u> 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harvey M. Weber Mary Padgett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverley Jenkins/Daughter 6440 Port Tobacco RD. La Plata, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; If Itel
any Injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State St. Ignatius Cemetery 5/5/2008 Hilltop, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M00945 21. Signature of Funeral Service Licensee 22 Name and Address of Eachty FUNERAL HOME, P.A. Cha C and 211 St. Mary's Ave. La Plata, MD 20646 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final resulting in death) Due to (or as a consequence of) Sequentially list conditions, if a place of a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 2 0 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy 2010 Be 25. Was case referred o medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1- Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🖾 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide cal 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. elever 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 102 amakshi Highway Date filed (Month, Day, State Registrar

Elijah Lynn Jime		State of Maryland / Department of Health 1- For State Registrar Certificate of Death		ygiene Reg	20	08 1605
Physici	an/	Decedent's Name (First, Middle,Last)		2. Date of Death	Day Year	3. Time of Death
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, bu			own, or Location of Death ashington	1	4c. County of Dea Prince Geor	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	1 Year If Under 24Hrs	8. Date of Birth	(MM/DD/YYYY) 9. I	
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Many r 28a	Director	10e. Street and Number 10f. Zip		109	. Citizen of What Co	ountry?
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Physician /Medical		23a. Part I, botter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line.	r dying, such as cardiac o	or respiratory arres	t, snock, or neart	Approximate Interval Between Onset and
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P. W. 5	Me	and manner stated. 29b. Signature and title of certifier 29c	License number		29d. Date signed (Month, Day, Year)
		Carol Adlan	O.C.M.E.		May 9, 2008	
		30. Name and address of person who completed cause of death (Item 23a)				
		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, E	Baltimore, MD 2120	01		
	ate					
Regis	ırar	MAY 1 6 2008 Sterene St. Sporte				
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1 and 2 Health a em 27 is		Terrye Jackson	/Daughter				ghts, M					
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Matilda H. So,
31. Date filed (Month, Day, Year) State APR 2 3 2008 Registrar



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	ms 23	by Funeral Director	11. Marital Status	12. Was Deceden	t Ever in U.S	S. 13. \		lispanic Origin	? (Specify Yes or N uerto Rican, etc.)		14. Race - Ame			
ပ္	after or iter	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give	i?] No				uerto Rican, etc.)		Black, Whi			
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notitied at		3 Nidowed 4 Divorced	Year or Dates	:		1 □ Yes 2 ☑ No	Specify:			Specify:	√hite ————		
5-0	72 h 'natu dical	Completed	15. Decedent's E (Specify only highest gr			(Give	dent's Usual Occup kind of work done	during most of	working	16b. K	(ind of Business	/Industry		
121	vithin ne. than e Me	mpl	Elementary/Secondary (0-12)	College (1-4or	5+)	_	DO NOT use retired retary	<i>a)</i>		Pol	ice Dep	artmont		
	Hygie Hygie ther i		17. Father's Name (First, Middle, Lasi	1)		560.	lecary	18. Mother's	Name (First, Middle			archienc		
an	d be ental ced o	o Be	George W. Carte					Beat	rice Fore	st	,			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	오	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	and Number o	r Rural Route Num	ber, City	or Town, State,	Zip Code)		
Š	nd 2 alth a 27 is		John Lotz	Son		912	Reserve C	hampio	n Dr., Ro	ckvi	.11e, MD	. 20850		
ē,	of Hei		20a. Method of Disposition	7	20b. P1	lace of Dispo	sition (Name of matory or other place	ce)	Date	20c. L	ocation - City or	Town, State		
E	Page nent c int: If		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (<i>Speci</i>		e		Cemetery	1 .	5/08	St.	Louis,	MO		
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or other tra		21. Signature of Euperal Service Lice	nsee	11	22	2. Name and Addre	ss of Facility	DeVol Fun	eral	Home			
<u>m</u>	8 4 E 8 8		Whit ON	NWH					r., Gaith		urg, MD	. 20877		
				Part 1. Enter the disease or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. declate Dause (Final asse of condition liting in death) a. Adult farture to Drive Due to (or as a consequence of): Due to (or as a consequence of): b. Due to (or as a consequence of):										
	Physician		mmediate Cause (Final disease of condition	- Adu	Lty	larl	use to	Pre	ve			Onset and Dea		
7	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	uence of):			10.					
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	rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	240 10 (0)	o di consequ					V				
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8760,	icate be executed physician and the burial-transit	dical		d										
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Box	th cer rendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pregnanc	v			23d. Date of de			
	e dea	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnant 9□Unknown	at time of de		Other (specify)	,			Month	Day Yea	ır	
P.0	at the	Physician/Me	9 ☐ Unknown Part II. Other significant conditions		but met soos	utting in the cu	ndarkina sausa sir	on in Bort I	220 Did	tohaana	una aantributa t	to the cause of deat	h2	
Š,	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as	b	Ost coxarrais				yetis, 4			Yes 2		robably 4 Junk		
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or Vital	Physician: this certific	Be	25. Was case referred to medical examiner?	Hospital:		FD/0-1	Oth		Death (Check only					
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on	nding th. : Afte fune	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, E	Day Year)	Injury		rƙ? ∣Yes 2∐No			,			
Division	Attending r death. ector: After by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of in	njury - At ho	me, farm, str	eet, factory, office		28f. Location City or To	(Street a	nd Number or F	Rural Route Number	r,	
	s afte	Sert	4 I Tomicide	building,	etc. (apecity	′)			Oily of 71	Jwii, Olai	.6)			
	To the Hospital or Attending Physician: The law Within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 ☐ Certifying P	hysician: To the bes	of examination	wledge, deat	h occurred at the ti	me, date and p	place, and due to the	e cause(s	s) and manner and place, and di	is stated. le to the cause(s)		
	the I the F	Medical	one)	and manner										
	So Jain	2	29b. Signature and title of certifier		1	/	29c. Licens		-		ate signed (Mor			
	1		> 14-Robert 2			-81)	00'	DIL	68/1/1	The second	1100,0	2008		
			30. Name and address of person who IL-ROBERT 30.				Print) XO1	THEO	SELL A SBURG	IL	1 200	777		
4	Sta	ite	31. Date filed (Month, Day, Year)		strar's Signa		9112	- 1/-			, ,	' /		
	Regist		MAY 0 2 2	008		K A	aske							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** William John Langrall May 2008 10:30a.™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1716 Perseus Road Cambridge Dorchester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 XM 2 ☐ F Director <u>214-12-6272</u> 86 Maryland 27, 1921 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Marylar 28a-f shov MD ; or Items 23a or 28a-f sl aminer must be notified Dorchester Cambridge 1 ☐ Yes 2 🔀 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1716 Perseus Road 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 May Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 'natural', or Iten dical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Yes 2 f Yes, Give 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🔀 No þ Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII Completed th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) agent real estate 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Harrison Langrall Eugenia May Flowers 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health and it item 27 is or other tra Jane Langrall wife 1716 Perseus Road, Cambridge, MD21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Maryland Veterans Cem. 5/7/08 Hurlock, MD 21. Signature Funeral Service Ligensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death Minn 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** TIMOCACDIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): physician Physician/Medical the attending properties for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig , page 2 should b 2 No 3 Probably 4 Unknown Dertension 1 ☐ Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy death? performed 2 100 1∐ Yes 2 **X**No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 000 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? or Attending To the Hospital Committee within 24 hours after death.

To the Funeral Director: After the Funeral Filled in by the fun 1 Natural Injury 5 Pending investigation 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State

altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Registrar

(Check only one)

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31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

and manner stated.

D.O.

32. Registar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARR

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Evelyn P. Malloy 2008 April 26. 3:41 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Center Prince Georges Cheverly 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number Hours Year) 1 □ M 2 1 F 224-48-4571 March 27 Alabama Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Prince Georges Upper Marlboro 1 □Yes 2XNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20772 3417 Village Drive North USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ※XXNo Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: Black If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Lampist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bennie Pritchett Mary Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3417 Village Drive North, Upper Marlboro, MD 20772 Denise Simpson - daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Comfort Cemetery 5/5/2008 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bell & Johnson Funeral Home, PA 21. Signature of Funeral Service Lig 6503 Old Branch Avenue, Temple Hills. MD 20748 23a. Pa t1. Enter the disease, or com-shock, or heart failure. List only Approximate Interval Between Onset and Death lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2. No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? H5 tory autopsy performed? 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖪 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner law requires that the death certificate be executed sician and burial-tran

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

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es 1 and 2 should be fill of Health and Mental H f item 27 is marked oth r other traumatic even

Pages 1 permit. Pages 1 Department of H Important: If ite any injury or ot

event, the Medical

within 72 hours after death with the

Baltimore, Maryland 21215-0036

Box 68760,

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Division of Vital Records,

Director

Funeral

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Completed

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physician as attending properties as signed by the a has page 2 certificate director, this funeral After t

Hospital or Attending Physician; Medical State Registrar

Examiner Physician/Medical ģ Completed Be Certification: To within 24 hours after death.

To the Funeral Urector A completely filled in by the fu

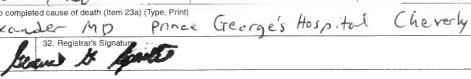
> Daniel 31. Date filed (Month, Day, Year) MAY 0 1 2008

4 Momicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0052815

29d. Date signed (Month, Day, Year)

	-	For State Registrar	tate of Maryland		rtment of H		Re	g. No.	08 1606
Physici /Medic	an	1. Decedent's Name (First, Middle, Last) Kenneth	W.	Мос			2. Date of Deat April 26,	2008	Year 3. Time of Death 11:00 P M
Examir	er	4a. Facility Name (If not institution, give stree Charlotte Hall Veterans	Home		4b. City, Town, or Charlotte	Hall		St. M	ary's
Funeral Director		5. Social Security Number 6. Sex XIXIXM	2□ F 7. Age (In yrs. la	as <i>t birthday)</i> Yrs.	if Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, April 2,	191 7	9. Birthplace (State or Foreign Country) Virginia
Maryland -f show led at	tor	Usual Residence of Decedent 10a. State 10b. County Virginia Fairfax		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2\sum_1 No
with the 3a or 28a st be notil	Funeral Director	10e. Street and Number 9015 Scott Street			10f. Zip Code 22153		1	USA	What Country?
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 Married	Was Decedent Ever in U.s Armed Forces? 1 ☑ Yes 2 □ No 194. If Yes, Give Year or Dates: 1961	/	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 HNo Specify: Specify				
filed within 72 h Hygiene. ther than "natu ent, the Medical	Completed	15. Decedent's Education (Specify only highest grade control (Spec	on <i>mpleted)</i> College (1-4or 5+)	uring most of working Self-Employed			ployed		
ould be filed Mental Hygi arked other atic event, t	To Be Co	17. Father's Name (First, Middle, Last) Leslie Moore		<u>-</u>		Essi		rrier	
1 and 2 should Health and Men tem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Hazel Moore / Wife		9015	Scott Street	t Springfie	eld, Virgi	nia 2215	
Pa Int:		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 ♣ Rem 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Incense	ovariiqin State _	ewood C		May 1,			rg, West Virginia ral Home P.A.
permit. Departr Importa any Inji		1 Ar & Kalan		1/2	6160 Oxon	Hill Road (Oxon Hill,	Maryland	d 20745 Approximate
Physician /Medical Examiner		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one disease or condition resulting in death) Sequentially list conditions.	Due to (or as a consequence)	2\$L V uence of):	43WL	r Acei)END		Interval Between Onset and Death 2 9 Es
cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to lininediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a conseq						
requires that the death certific een signed by the attending p hould be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	I death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	/			aate of delivery Month Day Year
quires that n signed b uld be deta		Part II Offier significant conditions contri	to Mellit	ulting in the u	inderlying cause giv	en in Part I.			ntribute to the cause of death? 3 ☐ Probably 4 ☑ Unkno
aw as b	Completed by	MILRONIC KIDA	VEG DISCAS	E			24a. Was autor perfo 1∐ Yes		Were autopsy findings availal prior to completion of cause of death? □ Yes 2 □ No
Physiclan: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hos	spital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie		er: 4 Nursing I	ath <i>(Check only o</i> Home 5☐ Resid	dence 6 □O	
or Attending ifter death. Director: After in by the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of injury - At h building, etc. (Speci	Injury ome, farm, st	M 1□	k? Yes 2 □ No		Street and Nun	nber or Rural Route Number,
the Hospital nin 24 hours a the Funeral npletely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	ian: To the best of my known: On the basis of examinating and manner stated.	owledge, dea ation and/or i	th occurred at the t nvestigation, in my	me, date and plac opinion, death occ	curred at the time,	date and place	e, and due to the cause(s)
To th To th comp	Me	29b. Signature and title of certifier			29c. Licen:	37-228	1	29d. Date eigh	hed (Montt, Day, Year)
10/1		30. Name an Laddless perso who com Stephen Cafferty M) 29449 Charlo	tte Hal	, Print) 1 Road Char	lotte Hall	, Maryland	20622	
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	y*				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of	Marylan		rtment of			_	giene Reg. No.	200	Q	16063
			Decedent's Name (First, Middle, I	ast)						2. Date of De	ath	4.00 NO. NO.		3. Time of Death
	Physicia /Medic	-	DIANE			MAR	TIN			Month 04	24		5 /	18:30 M
	Examin		4a. Facility Name (If not institution, g	rive street and num	reet and number) 4b. City, Town, or Location							County of De		
			Good Sama		ospito	2/	Balti	more	2					
- 1	Funeral		5. Social Security Number 5. Social Security Number 6. Sex 1 M 2 F F 57 Yrs. 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. NOV 2 1950									9. B	Country)	e (State or Foreign
	Director		Usual Residence of Decedent	Λ	37					NOV Z	1930	WA	SHII	NGTON, DC
	yland now at		10a. State 10b. County		10c. City	y, Town or Loc	cation						10d.	Inside City Limits
	a-f st	cto	MD PRINCE	GEORGE'S		HYATTS	VILLE							1X Yes 2 No
	ith the	Dire	10e. Street and Number				10f. Zip Code)				zen of What (Country'	?
	hours after death with the Maryland tural", or items 23a or 28a-f show ai Examiner must be notified at	Funeral Director	6909 DECATUR PL				20784					SA		4-31
	er de	une	11. Marital Status 1 ☐ Never Married 2 Married	Armed For	dent Ever in U. rces?	.S. 13. V	Vas Decedent of Yes, specify Co	f Hispanic Ori uban, Mexicai	igin? (Spe n, Puerto F	cify Yes or No Rican, etc.))-	14. Race - An Black, Wh		
36	ırs aft Il", or xami	P.	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	e	1	☐ Yes 2X N	lo Specify:				Specify:	BLA(CK
4NE 5-0036	2 hou	Completed by	15. Decedent's	Education		16a. Deced	lent's Usual Occ	cupation			16b. Ki	nd of Busines	s/Indus	try
21215	thin 7 e. an "n Medi	nple	(Specify only highest (Secondary (0-12)	College (1	-4or 5+)	life. E	kind of work dor OO NOT use reti	ired)	st of workin	ig				
	ed wi ygien her th	Co	12th			CLA	IMS EXA					VERNME	NT	
, and	be fill	Be	17. Father's Name (First, Middle, La WILLIAM MCGILL						er's Name EPHIN	(First, Middle IE LOW		Surname)		
$7/\mathcal{N}$ arylan	hould d Mei narke	P	19a. Informant's Name/Relationship			10h Mailin	g Address (Stre					Town State	Zin Co	200
Ma	nd 2 s Ith an 27 is : traui		CONNY MARTIN/H	, , , ,			DECATUR ¹							,
re, 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition			lace of Dispos	Sition (Name of natory or other p	i		ate		cation - City		
$\mathcal{M}_{\mathcal{A}_i}$ Baltimore,	Page tent o nt: If ry or		1 XBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		state i		CEMETER'		5/1/2	800	LAN	DOVER,	MARY	YLAND
<u>a</u>	permit. Departm Importa any inju once.		21. Signature of Funeral Service U	сепѕее	-	22	. Name and Add	dress of Facili	ty J.	B. JE	NKIN	S FUNE	RAL	HOME
8			Nuary	aden	al		7474 LA	NDOVER	ROAD	LANDO	VER,	MARYL	AND	20785
	5.348		23a. Part1. Enter the disease of co shock, or heart failure. List or	omplications that cally one cause on ea	aused the deat ach line.	h. Do not ente	er the mode of o	dying, such as	cardiac o	r respiratory a	ırrest,		l In	pproximate Iterval Between Inset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. SE	PSIS									riset and Death
4	/Medical Examiner		resulting in death)	100	or as a conseq		ALCEU AL	2000						
		<u>-</u>	Sequentially list conditions,	b. Due to I	or as a conseu	uence off:	NEUMO	10/4					+	
	uted J ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	ACL	ITE R	ESPIK	RATORY	Di	TRE	SS SY	ルカム	2014		
o,	exec an and rial-tra	Еха	resulting in death) Last	Due to (or as a conseq	uence of):								
8760,	cate be executed oblysician and the burial-transit	dical		a chi	TEMI	C LL	ipus 1	ERYTI	HEM	ATOUS	`			
9	artifica ing ph e as tl	Med	IF FEMALE:										-	
Вох	leath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?		irth 2 🗆 Feta	aldeath 3⊑	Ectopic pregna				1	23d. Date of o	delivery Da	ay Year
o.	the de	Physician/Me	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4⊟Pregn 9⊟Unkno	ant at time of d	ieath 5	Other (specify)	,						
σ.	Physician: The law requires that the death certificate has been signed by the attending I this certificate has been signed by the attending I ral director, page 2 should be detached for use as	/ Ph	Part II. Other significant condition	s contributing to de	eath but not res	ulting in the ur	nderlying cause	given in Part i	l.	23e. Did	tobacco ι	use contribute	to the	cause of death?
rds	w requires t been signe should be	d by								1 🗆	Yes 2	Ø No 3□	Probab	ly 4 ∐Unknown
၀	law rei as bee 2 shoi	Completed								24a. Was		24b. Were	autopsy	y findings available
Ä	The Late ha	mo								auto perf	ormed? 2 No	death	?	etion of cause of
Ita	ysician: The lav is certificate has director, page 2	Be C	25. Was case referred to medical examiner?					26. Place	e of Death	(Check only				
\ \rac{r}{\}	hysic this co	To	1 ☐ Yes 2 ☑ No		-	ER/Outpatien	I OLI DOA			ne 5□Res			pecify)	
Division or Vital Records,	ing Phys	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	in the second se	of Injury th, Day Year)	28b. Time of Injury	V	njury at Vork?		28d. Describe	how inju	ry occurred		
isi	Attending r death. ector: After by the funer	icat	2 Accident investigat 3 Suicide 6 Could no	be 280 Place	of injury - At he	ome. farm. str	eet, factory, office	☐ Yes 2☐		P8f Location	(Street an	nd Number or	Rural F	Route Number,
Ω̈́	after after Dire	Certification:	4 ☐ Homicide determine	buildi	ng, etc. <i>(Specil</i>	fy)	, ,,			City or To				,
	e Hospital or Attending Ph 24 hours after death. 9 Funeral Director: After thi etely filled in by the funeral			Physician: To the										
	To the Hos within 24 hd To the Fun completely	Medical	one)	caminer: On the ba	asis of examina ner stated.	anon and/or in			atri occurr	eu at the time				
	7 wit	2	29b. Signature and title of certifier	MD)			ense number)		29d. Da	te signed (Mo	onth, Da	ny, Year) 7
	(12)		Juane			00.1.7		s 00c			07	1/27/	UA) -
CK	イブ		30. Name and address of person w	no completed caus	e of death (Item 20 SAM+	n 23a) (Type, 1 R / / A/V	HOSPITA	1L, 56	101	LOCH K	AVE	N BLU	10	995
			21 Date fled (Month Day Voor)		enistrar's Sin			15+	74/1/	TUKE	1910	, 2123	J - 2	-001

State Registrar

PREGISTRAT APR 3 0 2008

DHMH 17 Rev 1/2001

Date filed (Month, Day, Year)

APR 3 0 2008

32. Registrar's Signature

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	01-1-	. C A A	to and ID.		a militar and all history	بمحال الماسم	

		-	For State Registrar	State of Maryland	•	tificate of L			giene Reg. No 2 () (18 60	64
	Physicia	an	Decedent's Name (First, Middle, Last)	T MOUNT				2. Date of De Month	Day Y	3. Time of D (ear 8:10	
	/Medic Examin	_	MARIE 4a. Facility Name (If not institution, give s	F • MOUNT	AIN	4b. City, Town, or	Location of Deat	APRIL	29, 20 4c. County of		r
			HOLY CROSS HOSPI				LVER SPR			TGOMERY	
	Funeral Director		5. Social Security Number 6. Sex 186–20–9953	7. Age (In yrs. I. 83	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	, 1924	9. Birthplace (State or I Country) PA •	roreign
	D	Ì	Usual Residence of Decedent 10a, State 10b, County		, Town or Lo	cation				10d. Inside City	Limits
	Maryla f shov led at	ō	MD. PRINCE G		,	HYATTSVI	T.I.F			1x Yes 2	2 □ No
	r 28a- r notifi	Director	10e. Street and Number	EORGES		10f. Zip Code			10g. Citizen of Wh	at Country?	
	ath with		7973 RIGGS R				0783		U.S.	A . - American Indian,	
9	be filed within 72 hours after death with the Maryland Hygiene. dother than "natural"; or items 23a or 28a-f show do other than "natural"; or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 【 No		to Rican, etc.)	Black, Specify:	White, etc.	
5-0036	thours atural		3 Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Usual Occup	ation	alain a	16b. Kind of Bus	WHITE iness/Industry	
۲۱2 د اع	within 72 iene. than "na the Mediu	ompleted	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. I	kind of work done o	1)	rking		_	
N	filed wil Hygien ther th ant, the	O	12 17. Father's Name (First, Middle, Last)			HOMEMAI		me (First, Middle	HOM: , Maiden Surname		
anc	ould be fi Mental H Iarked ot natic ever	To Be		ACCIO				CLARA	NATA		
Maryland	ts Pi	Ĕ	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailir	ng Address (Street	and Number or R	ural Route Numb	per, City or Town, S	tate, Zip Code)	
	and 2 lealth a m 27 is		LINDA M. BARBER/		7973	RIGGS I	RD. #2,	HYATTSVI Date	LLE, MD.	20783	
9 6	Pages 1 nent of H nt: if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	emoval from State	emetery, crei	matorý or other plac	t			,	
Baltimore,	permit. Pag Department Important: i any injury o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service (Scens	ee / sn	22	CREMATO 2. Name and Addre CHAMBERS	ss of Facility FUNERAL	-2008 HOME &	CREMATOR	ALE, MD. IUM, P.A.	
3	20 = a 0	n Interior	23a. Part1. Enter the disease, or compl	M000 ica ons that caused the death					VERDALE,I	MD • 20/3/ Approximate Interval Betw	veen.
	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	SEPSIS						Onset and Do	eath
	/Medical		resulting in death)	Due to (or as a conseq	uence of):						
	Examiner	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	CHRONIC RES		RY FAILU	RE				
50,	cate be executed physician and the burial-transit	I Exa	resulting in death) Last	Due to (or as a conseq	Due to (or as a consequence of):						
68760	ficate b physic s the b	edical		J							
Box	ath certii attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	у		23d. Date Mon	of delivery th Day Y	'ear		
ds, P.0	juires that the de isigned by the a ld be detached i	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	ınderlying cause giv	ven in Part I.			bute to the cause of de 3□ Probably 4¶U	
Vital Records,		Completed						24a. Was auto peri 1∐ Yes	opsy p formed? d	/ere autopsy findings a rior to completion of ca eath? □Yes 2□ No	available ause of
/ita	Attending Physician: The r death. ector: After this certificate h. by the funeral director, page	Be C	25. Was case referred to medical examiner?	Hospital:		Ott	10r:	ath (Check only			
	Physi rthis c ral dire	٠ <u>.</u>	1 ☐ Yes 2 ☐ XNo 27. Manner of Death	28a. Date of Injury	ER/Outpatie 28b. Time of	III 3 DOX	4 Li Nuising		how injury occurre		
on	nding Pt ath. r; After the funeral	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk?]Yes 2 ∐No				
Division or	크를들트	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Special		reet, factory, office		28f. Location City or To	(Street and Number own, State)	er or Rural Route Numi	ber,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 X Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, dea ation and/or i	th occurred at the t nvestigation, in my	ime, date and pla- opinion, death oc	ce, and due to the	e cause(s) and mai e, date and place, a	nner as stated. and due to the cause(s	;)
	To the within To the comple	Me	29b. Signature and title of contifier			29c. Licen	se number		29d. Date signed	(Month, Day, Year)	
)	5		1				2571		APRIL	30, 2008	
			30. Name and address of person who c				LEN RD	STLVER	SPRING	MD. 20910	
	St	ate	DR. SARAH BROM 31. Date filed (Month, Day, Year) MAY 0 2 200	ELAND, M.D. Régistrar's Sign	ature _		LLIN KD.,	DILIVER	DIRINO	. 20010	
	Regist		MAY U 2 200	8 Klains &	K And	action in					

			_ For	State of Mar	yland / Depa	rtment of H	lealth and	Mental Hyg	jiene			
			- State Registrar Amend #2,perM),g879 5/28/C	08 TT Cer	tificate of I	Death		leg. No.	08	161	365
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month 2	th Day	Year	3. Time of	Death
	/Medic			e Crawford	Martin			April 2	4 , 2008		6:50	ΑM
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or		th	4c. County			
			5821 Queens Chap 5. Social Security Number 6. Sec		(In yrs. last birthday)	Hyatts If Under 1 Year	SVILLE If Under 24 Hrs	8. Date of Birth			orges	r Foreian
	Funeral Director]M 2 X]F	91 Yrs.	Months Days	Hours Min.		, Year)	Countr	otte,	
7	for agine or age		Usual Residence of Decedent					Dec. 19	1710			
0	show	_	10a. State 10b. County	1	10c. City, Town or Lo	cation				100	d. Inside Cit 1 ဩYes	
M	8a-f s	Director	MD Prince	Georges	Chill:							
4	a or 2 be no		10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Countr	y?	
4	ns 23	eral	6115 Rosedale Dri	Ve 12. Was Decedent Ev	verin IIS 13 \	2078		Specify Yes or No-		- S - - Americai	n Indian.	
	7.2 nous arier ueath with the wayran "natural", or items 23a or 28a-f show idioal Examiner must be notified at	Funeral	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 🔀 No		_		Specify Yes or No- rto Rican, etc.)	Black	, White, et	tc.	
5-0036	rurs a ral', o Exam	by	3 ☐ Widowed 4 🎛 Divorced	If Yes, Give Year or Dates:		I∐Yes 2 ⊠ No	Specify:		Specify:		cican	
i c	natur	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced	lent's Usual Occup	ation during most of wo	orkina	16b. Kind of Bu	siness/Indu	istry	
7	ne.	du l	Elementary/Secondary (0-12)	College (1-4or 5+)) life. L	OO NOT use retired	i)		•			
7	be lied whith 72 hours after beath with the inarylating that Hygiene. tal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		12 17. Father's Name (First, Middle, Last)		Bak	er	18 Mother's Na	me (First, Middle,	Nationa Maiden Surnam		ograph	iic
Maryland 21	antal h	Be c						_				
2	is 1 and 2 should be lied within 72 its learly and Mental Hygiene. Item 27 is marked other than "natu other traumatic event, the Medical	၉ ,	Edward Rogers 19a. Informant's Name/Relationship (Ty	rpe. Print)	19b. Mailin	a Address (Street		Le Crawfo			Code)	
	and 2 sealth ar n 27 is ner trau	i	Cordelia M. Shepl		ghter 6115	,					/	
e j	othe		20a. Method of Disposition		20b. Place of Dispo			Date	20c. Location -		n, State	
ב פ	rages nent of int: If It	Νí	1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Rock Cree		1	2. 2008	Washin	gton.	D.C.	
	permit. Prage Department of Important: If any Injury or once.		21. Signature of Funeral Service Licens	ee	22	. Name end Addre	ss of Facility Mo	Guire Fu	neral S	ervic	e, Ind	c.
מ מ	825 8 8	2.4	Undre Th	comple		7400 Geor	gia Ave	, N.W. W	ashingt	on, D	.C. 20	012
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the cause on each line	he death. Do not ent	er the mode of dyir	ng, such as cardia	ac or respiratory are	rest,		Approximate Interval Bet Onset and D	ween
	hysician		Immediate Cause (Final disease or condition resulting in death)	Alzhe:	imers Dise	ease					5 Year	
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):							
		r o	Sequentially list conditions,	Due to (or as a	consequence of):					_		
7	ured Insit	Examiner	If any, leading to immediate cause. Enter Underlying Cause Uisease or injury that initiated events							-		
o e	exection and the rial-tra	Exa	resulting in death) Last	Due to (or as a	consequence of):							
8760,	ate be executed thysician and the burial-transit	dical		d								
9	ng ph	Med	IF FEMALE:									
Вох	e attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pt 1 ☐ Live birth 2	Fetal death 3	Ectopic pregnanc	у		23d. Dat	e of deliver	-	Year
	0 0	/sic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4∐Pregnant at ti 9∐Unknown	ime of death 5L	Other (specify) _					-,	
۽ ع	Ine law requires that the tee has been signed by the age 2 should be detache		Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contr	ibute to the	cause of d	eath?
Vital Records,	ures sign d be	d by	Cerebral Vascular	Accident				1 🗆 Y	′es 2∑XNo	3 Proba	ıbly 4 □l	Jnknown
S	s been signature should b	Completed	Hypertension					24a. Was a		Vere autop	sy findings	available
<u>۽</u> ۾	cate has l	dwo					-		rmed?	leath?	npletion of ca 2 □ No	ause of
		Be C	25. Was case referred to medical				26. Place of De	1 Yes eath (Check only o		Lites 2	2 140	-
>	nysici lis cel direc	To B	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 ☐ Inpatient	t 2 ER/Outpatier	t 3 DOA Oth	or	Home 5 ☐ Resid		er (Specify)	Hospi	ice
n or	ng Pri fter th		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	28b. Time o	28c. Injui Wor	ry at rk?	28d. Describe h	now injury occurr	ed		
Ois	endi eath. or: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No					
Division	fter de din by in by	Certification:	4 Homicide determined	28e. Place of injury building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Rural	Route Num	ber,
	piral ours a eral [29a, Certifier 1X Certifying Phy	sician: To the best of	my knowledge deat	h occurred at the ti	me date and plac	ce and due to the	calleg(e) and ma	nner as sta	ated	
	To the nospital or Attending Priystcan: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director; to	edical		iner: On the basis of and manner state	examination and/or in							i)
	Mithin To the	Me	29b. Signature and the of certifier			29c. Licens	se number		29d. Date signed	d (Month, D	Day, Year)	
,	4		1/1/1/0			00g	51391		April 30	200	08	
	/		30. Name and address of person who c	ompleted cause of dea	ath (Item 23a) (Type,				·	,		
			Gary W. Thompson,		ving Stree	et, NW Su	ite 216	Washingt	on,DC 20	0010		
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 2 200	Registrar		AF 0						
1	negisti	al	0 5 200	- Jugar	10 1900							

			For State Registrar	State of	Marylar		artment o		and Me		giene Reg. No.	2008	16	065
			Decedent's Name (First, Middle	e, Last)					2	2. Date of De	ath		3. Time of	Death
	Physicia		Marguerite An	ne McCrea					A	Month April 2	Day 2	2008 Ye <i>a</i> r	4:01	рм
	/Medic		4a. Facility Name (If not institution				4b. City, Tow	n, or Location of		1		County of Death		
			Suburban Hosp	oital			Beth	nesda				Montgome	ry	
F	uneral		5. Social Security Number	6. Sex 7	. Age (In yrs.	last birthday) 97 Yrs.	If Under 1 Ye Months Da		24 Hrs. 8 Min.	B. Date of Bir (Month, Da	th y, Year)	9. Birthi Coul	olace (State ontry)	r Foreign
D	irector		453-74-7437 Usual Residence of Decedent			97 Yrs.			,	(Month, Da Jan 7	,191	l New	York	
land	WC T		10a, State 10b. County		10c. Ci	ty, Town or Lo	cation					1	0d. Inside Ci	ty Limits
Mary	-f sh	ţō	D.C.	lone	Was	hingto	n, D.C.						1 ⊠Yes	2 🗆 No
the	r 28a	irec	10e. Street and Number				10f. Zip Cod	ie			10g. Citi:	zen of What Cou	ntry?	
th with	23a o	alD	4201 Cathedral	Ave., N.W	. #7	09	200	16				U.S.A.		
r deal	ems	Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U	.S. 13. \	Was Decedent f Yes, specify (of Hisp <i>a</i> nic Ori	gin? (Spec	ify Yes or No	. .	14. Race - Americ		
s afte	or it	by Fu	1 Never Married 2 Marr	ied 1 ☐ Yes 2 If Yes, Give	≧ <mark>IX</mark> No		l∐Yes 21∏						ite	
5-0036 72 hours aff	tural' al Ex	ed b	3 ☑ Widowed 4 ☐ Divorced 15. Deceden	Year or Dat	es:	16a Decer	dent's Usual Oc	cupation			16h Kir	nd of Business/In	dustry	
U 72	n "na	Completed	(Specify only highes	st grade completed)		(Give	kind of work do	ne during most tired)	t of working	7	TOD: TO	id of Dusiness/iii	duotry	
ž į	rtha	E	Elementary/Secondary (0-12)	College (1-4	tor 5+)	Home	Maker				Ow	n Home		
D eile	othe vent,	BeC	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name ((First, Middle,	Maiden	Surname)		
yland wid be file	arked	일	Peter Lengline	<u> </u>				L:	ise 1	Martin				
Mar 12 sho	is mid		19a. Informant's Name/Relations				•					r Town, State, Zij	Code)	
and S	or neart and wetter trygene. The surface of the than "natural", or items 23a or 28a-f show other traumatic event, the Avidical Evandration and the notified at		Michael McCrea	/ Son	Tan. s					-		. 20008	C4-4-	
ges 1	or of		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 ☑ Removal from S	tate	cemetery, cren	sition (Name of natory or other	place)	Da May 1			cation - City or To		
it. Pa	rtant njury		4 □ Donation 5 □ Other (S		Met		tan Cre	ematory	20	08		andria,	Virgin	ıia
De m	Important: If item 27 is any Injury or other trau		21. Signature of the eral Society	Conste				dress of Facilit				l Home hington,	D. C. 2	20007
			23a. Part 1. Enter the disease, or	complications that ca	used the deat							ningeon,	Approximat	e
Dhy	sician	ž 18	shock, or heart failure. List Immediate Cause (Final	•		ntwioui	lar Arr	hythmia					Interval Bet Onset and	
1	ledical		disease or condition resulting in death)		ras a conseq		Lat All	ily Cilmia				-		
Exa	aminer			, Stro	ke- CV	A								
р	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (o	г ев а сспвис	uwnov off:								
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DO /	phys s the	dical		d										
ath certif	nding Jse a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo							2	23d. Date of deliv	erv	
death	e atte	icial	in the past 12 months? 1 ☐ Yes 2 ☒ No	4 ☐ Pregna	rth 2 ☐ Feta ant at time of o		∃Ectopic pregn ∃Other <i>(specif</i>)					Month	-	Year
j. å	by the	hys	9 🗆 Unknown	9 🗆 Unkno	wn									
S, L	gned se de	by P	Part II. Other significant condition	ons contributing to dea	ath but not res	ulting in the ur	nderlying cause	given in Part I.		23e. Did t	obacco u	se contribute to t	he cause of o	leath?
ecorus law requires	en si ould l	ē							_	1 🗆 '	Yes 2	□ No 3 □ Pro	bably 4 🔯	Unknown
aw r	as be	Completed								24a. Was		24b. Were auto	psy findings impletion of c	available ause of
L e	page	Sol I								perfo	rmed? 2 🐼 No	death? 1 □ Yes		
VII.all	sertifik actor,	Be	25. Was case referred to medical examiner?						of Death	(Check only o	ne)			
Physi	this o	၉	1 Yes 2 No			ER/Outpatier	IL S LI DOA					Other (Speci	fy)	
Attending Phy	After funer	io	27. Manner of Death 1 XNatural 5 ☐ Pendin 2 ☐ Accident investig	9 1 '	, Day, Year)	28b. Time of Injury		Injury at Work? 1 ∐Yes 2 ∐I		3d. Describe	now injur	y occurred		
Atten	ctor:	fical	3 ☐ Suicide 6 ☐ Could I	not be 28e. Place of	of Injury - At h	ome, farm, str	eet, factory, offi			Bf. Location (Street an	d Number or Run	al Route Nun	nber.
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the t	the I	Med	one) 29b. Signature and title of certifie	and manne	er stated.	/	29c Lic	ense number			29d Dat	e signed (Month,	Day Year)	
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3		1	30. Name and address of person	who completed cause	of death (Iter	n 23a) (Tvoe	Print)	16-	7		1	1100)	
			Eva Hausner			, , , , ,		wn Rd B	ethes	da,Md.	208	14		
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 2		gistrar's Signa		and a							
							The same of the sa							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 54AM mar 04 2008 Meredith Anita Marie /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner ambr xorchester Social Security Number 9. Birthplace (State or Foreign Date of Birth (Month, Day, **Funeral** Days 1 ☐ M 2 🔀 F 214-12-6224 85 1922 Pennsylvania **Director** Nov. Usual Residence of Decedent 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show sdical Examiner must be notified at Yes 2 No MD Director Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 415 Glenburn Ave. 21613 USA by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: white 3 N Widowed 4 □ Divorced Completed Injury or other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) wire cloth mfq. 11 secretary Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be finance and Mental F David W. Horner Lillian Dryden ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tem 27 Donna Justice daughter 422 Oakley St., Cambridge, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 □ Burial 2 □ Cremation 3 □ Removal from State Old Trinity Churchyard 5/8/08 4 ☐ Donation 5 ☐ Other (Specify) Church Creek, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** hours disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner AR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. ied by the attending physician detached for use as the buris Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be de Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 200 1 🗌 Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ 16 autopsy 25. Was case referexaminer? ed_to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Tes ၉ 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No ∠ □ Accident after death Director: completely filled in by the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

JEREDITH, Anita

Registrar

30. Name and address of person w

31. Date filed (Month

13

DHMH 17 Rev 1/2001

Blable SI

empleted cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** BISHAMBAR Month Day Year MAHAJAN 2:10 AM 2008 pail 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kline Hospice Health Frederick Mount Airy 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 26,1925 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1**⊊**M 2□F Months Hours Min. Days 219-88-0020 82 **Director** India Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notifled</u> at Maryland Frederick Mount Airy 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7000 Kimmel Road 21771 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Specify: Asian Indian 1 ☐ Yes 2X No ģ Specify. 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Musician Music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fit of Health and Mental F Item 27 Is marked otl Be Indira Mahajan Chuni Lal Mahajan ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2990 Summit Drive, Ijamsville,MD 21754 19a. Informant's Name/Relationship (Type. Print) Ellen Mahajan/Sister-In-Law 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Iter
any injury or oth 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State George town University April 16 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 Donation 5 ☐ Other (Specify) 2008 Medical School 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Signature of Funeral Service Licer 9013 Annapolis Road, Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MULTIPLE disease or condition resulting in death) UNKNOW /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Huknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1□ Yes 2 No 2 □ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) VILINE Other: 4 Nursing Home 5 Residence 6 State (Specify) HOSPICE (409) Hospital: 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760 Division or Vital Records, Hospital or Attending Physician: in 24 hours after use the Funeral Director: Af To the vithin 2

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

GEORGE

(Check only one)

29b. Signature and title of certifier

1. (M.Tit 31. Date filed (Month, Day, Year) APR 23 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

MEDICAL



DIRECTER

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

516 TRAIL

D10587

HOSACE OF FREDERICK COUNTY

29d. Date signed (Month, Day, Year)

FREDERICK

22, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryiana / Depa Cei	artment of r rtificate of			leg. No.	108	16069
		-4:	Decedent's Name (First, Middle, La	nst)	1			2. Date of Dea	ith		3. Time of Death
В	Physici /Medic		Pamela (Middle	ton			APR	Day 15	Year 2008	22:42 M
	Examir		4a. Facility Name (If not institution, give	1	1 6 1	011	or Location of Death		4c. County	of Death	
	<u> </u>		University at Mar 5. Social Security Number 6.5	yland Medica	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	,	Q Rirthr	place (State or Foreign
	Funeral Director		217-72-4642	1 □ M 2 🟋 F	48 Yrs.	Months Days	Hours Min.	Oct.29	(, Year)	Coun	nington, DC
	land Sw		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	Mary a-f sh	tor	MD Prince	Georges		Laure	l				1 XYes 2 No
	ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Cour	itry?
	ath w	ral	13503 Attleboro				708			USA	
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	y Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 V If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 □ Yes 2🌠 No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specify	ce - Americ ck, White, y: B1	
21215-0036	72 hour 'natural dical Ex	Completed by	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usual Occu kind of work done	pation during most of work d)	ing	16b. Kind of B	usiness/Inc	dustry
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	filed Hygid other ent, th	Be Co	17. Father's Name (First, Middle, Las.	t)	CHILC	i care i	18. Mother's Nam	e (First, Middle,			
lan	ould be filed withi Mental Hygiene. arked other thar atic event , <u>the M</u>	To B	John Gilbert E	uchanan			Delma	Virgin	ia Fry	'e	
Maryland	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship	(Type. Print)	19b. Mailii	ng Address (Street	and Number or Ru	al Route Numbe	r, City or Town,	State, Zip	Code)
	1 and Health em 27 other tr		Samuel J. Middl	eton/Hus	band 13503 20b. Place of Dispo			#23, La			20708
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		cemetery, cre	matory or other pla	ice)		20c. Location -	_	
i	permit. Pages Department of I Important: If ite any injury or of		4 ☐ Donation 5 ☐ Other (Special Signature 1	psec			etery 4/		Laure		neral Home
B	permi Depar Impor any ir		16/60	100							DC 20011
	2 2	<	23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each li	the death. Do not ent	ter the mode of dyi	ng, such as cardiac	or respiratory an	rest,		Approximate Interval Between
	Physician		Immediate Caus Final disease or condition resulting in death	a inters	stitial	Dulmor	nary fi	brosis		E	Onset and Death
1	/Medical Examiner		resulting in dealing	Due to (or as	a consequence of):	1	J				·
	190	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as	a consequence of):						
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68760,	tificate be executed g physician and as the burial-transit	edical		_d							
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Ö	w requir s been si should	lete)'					24a. Was a	an 24b.	Were auto	psy findings available
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	To the Hospital or Attending Phywithin 2 thours after death. To the Funeral Director: After this completely filled in by the funeral directors.	Medical C	29a. Certifier 1. ★Certifying P (Check only one)	hysician: To the best miner: On the basis o and manner st	of my knowledge, deat f examination and/or in ated.	h occurred at the to estigation, in my	ime, date and place opinion, death occu	and due to the cred at the time,	cause(s) and made and place,	anner as s and due to	tated. o the cause(s)
	To th To th Comp	Me	29b. Signature and title of certifier			29c. Licens	se number 76435 L 1815	9	29d. Date signe	Month,	Day, Year)
	2			MO		10071	1010/41010	1	4/15/	08	
	ن		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type,	Print)	900 0	11	md 21	1331	-
	Sta	to	Jonathan Lissaue: 31. Date filed (Month, Day, Year)		ar's Signature	partment	909. B	Immore	ind of	100	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physicia /Medica Examine

Funeral Director 1 - For State Registrar

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

Division or Vital Records, P.O. Box 68760,

an al	John ARthu	r 09/E	, Jr.				APRI		,2008		5PM
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	5. Social Security Number 6. S		e (In yrs. last birth 64		er 1 Year If	Under 24 H lours Mi	rs. 8. Date of Bi	rth	9. Bir	thplace (State or ountry) hington,	
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ral Dire	10e. Street and Number 30 Locust St. #20	9			Cip Code			10g. Citi USA	zen of What C	ountry?	
Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent If Armed Forces? 1 Yes If Yes, Give Year or Dates:		If Yes, sp	ecify Cuban, I	inic Origin? Mexican, Pu pecify:	(Specify Yes or No erto Rican, etc.)	0-	14. Race - Ame Black, Whi Specify: Wh	te, etc.	
Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5	(i+)	Decedent's Us Give kind of v life. DO NOT duce We	,	n ng most of w	vorking		nd of Business	,	
To Be (John Arthur Ogie, 51.										nk)
	19a. Informant's Name/Relationship (Wanda G. Sams/Dome		ner 30	Locus	t Stree		9 Westmi	nster	, MD 2	1157	
	20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		20b. Place of I cemetery Chesape	, crematory o	r other place)	у 05	Date /03/08		sville,		
	21. Signature of Funeral Service Lice	ettto	MO1251	Bever	lv L. H	leckro	ion Serv	. Cla		le, MD 2	
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Σ	29b. Signature and title of certified	Nay	M	n	9c. License nu 2005–9				te signed (Mon	th, Day, Year) 30 , 200	38
	30. Name and address of person who	completed se of de	eath (Item 23a) (T	ype, Print)						10.522	

Registrar DHMH 17 Rev 1/2001

State

G-UURISHANEAR

MAY 0 5 2008

31. Date filed (Month, Day, Year)

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Poole ROAD WESTANSTER MID

MAGANNA

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** AM 30, 2008 ROY BENJAMIN PHILLIPS APRIL 5:30 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner QUEEN ANNE'S 1730 HARBOR DRIVE CHESTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days 1**X** M 2□ F 222-16-3174 80 AUGUST 6,1927 DELAWARE Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location ırai", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND QUEEN ANNE'S CHESTER 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 1730 HARBOR DRIVE 21619 UNITED STATES Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates:**1945—1946** 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: WHITE þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) UNITED METHODIST al Hygiene. Pages 1 and 2 should be filed within tment of Health and Mental Hygiene.
 Tant: If item 27 is marked other than jury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) CHURCH MINISTER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM E. PHILLIPS MOLLIE L. FOSKEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) THELMA WHALEY PHILLIPS/WIFE 1730 HARBOR DRIVE, CHESTER, MARYLAND 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page Department o Important: If any Injury or 1 YBurial 2 □ Cremation 3 □ Removal from State STEVENSVILLE CEMETERY 2008 4 □ Donation 5 □ Other (Specify) STEVENSVILLE, MARYLAND 21. Signalate of Fun Service Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Drostate Cancer Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Each of the figure (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-trar Due to (or as a consequence of) physician Physician/Medical the 35 IF FEMALE: ISe 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year õ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached i 9∏Linknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 has autonsy performe certificate 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one Be Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 ☐ DOA P 1 🔲 Inpatient this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.O. Box 68760, Division or Vital Records, or Attending † hours after death. •uneral Director: A ely filled in by the fu within 24 hours after To the Funeral Dire completely filled in b

Saltimore,

1 Pritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

GODDMAN, 170. 2540 (ENHAUTE Rel, CENHAUTE) 11017

Registrar

Medical

31. Date filed (Month, Day,

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2020M 08 Lee Parsons /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** NI COMICO 30/138UR eninsula REGIDNAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) ial Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) 1 X M 2 □ F Months Days Hours Min. Yrs. Maryland 219-46-3908 2-24-1947 Director 61 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Evarriner must be published at 1 Yes 2 □ No Director Wicomico Delmar 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10 West Elizabeth Street 21875 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ages 1 and 2 should be filed within ent of Health and Mental Hygiene. It: If Item 27 is marked other than "y or other traumatic event, I' a May Elementary/Secondary (0-12) College (1-4or 5+) 8 Gated Community Gate Keeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Ear1 Parsons Easter **Ethel** Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julianne Parsons – wife 10 West Elizabeth Street, Delmar, MD 21875 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Crematory of Delmarva 5-1-2008 4 ☐ Donation 5 ☐ Other (Specify) Delmar, Delaware 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, MD 21804 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Physician; The law requires that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. physician by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3

Ectopic pregnancy for Month Dav Year 5 ☐ Other (specify) signed by the a 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 🗔 NO 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🖫 inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending nours after death.

neral Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Funeral L Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

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State Registrar

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31. Date filed (Month Pax

atle of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

0 2 2008

29b. Signature as

POWCY

D54127

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** May 2, 2008 7:15 A M Funkhouser Russ /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 3318 University Blvd. West Kensington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) Funeral Months Days Hours Min. 1 ☐ M 2 💢 F 579-12-3351 87 Director Jan 7, 1921 Virginia Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director MD Montgomery Kensington 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r USA 3318 University Blvd. West 20895 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2√2 No Specify. Specify: 3 Widowed 4 □ Divorced White Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Travel Specialist Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ith and Mental 27 is marked of traumatic ever Ethel Rinker Charles Funkhouser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19125 Alpenglow Lane Brookeville, MD 20833 Mollie R. Deck/daughter 20a. Method of Disposition

1 Burial 2 Eremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot once. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 05/05/08 Beltsville, MD 21. Signatu of Funeral Service Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a. Pneumonia /Medicai Due to (or as a consequence of) Examiner Advanced Alzheimer's Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): Physician/Medica! the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛱 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Was a. autopsy performed? 24a. Was an 1∏ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2X No 5 Residence 6 □Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1X Natural 5 Pending investigation Injury 1 □ Yes 2 □ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check o one) and manner stated. 29b. Signature 29c. License number and title of certifier 29d. Date signed (Month, Day, Year) May 2, 2008 D64615

law requires that the death certificate be executed

physician

this

Director:

i or Attending F after death.

Hospital

To the within 2.

Box 68760,

Division or Vital Records, P.O.

31. Date filed (Month, Day, Year)

Genevieve Wroblewski, M.D. 1355 Piccard Drive Rockville, MD 20850 Begistrar's Signature 32.

MAY 0 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

show

with

death

filed within 72 hours after

natural",

Hygiene.

Mental and 2 should be

Health Item 27 i

other

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Sorrel **Physician** 154 35 2008 766 PY SLIC /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Bushey 20 mer 2513 Moa 9. Birthplace (State of Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 68 June 28. 218-38-8775 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County sa or 28a-f show t be notified at show 1 X Yes 2 □ No Directo MD Wheaton Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12513 Bushey Drive 20906 U.S.A. rai", or items 23a Examiner must b Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Specify: 3 ☐Widowed 4 ☐ Divorced Year or Dates 'natural", er than "natura , the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer/Driver Warehouse/Storage nt of Health and Mental Hyg If Item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nelson Webster Sorrell Anna Eugena Cookman ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Mary Sorrell (Sister-in-law) 12513 Bushey Dr., Wheaton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 X Removal from State Department of Important: If any injury or once, Cremation Center 4/29/08 Chantilly, Virginia 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1102 W. Broad St Falls Church, aurence Murphy Falls Church Funeral Home VA. 22046 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1116 16 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or nighry that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and strans Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death been signed by the s should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) 12 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death neral Director: / filled in by the f 2 Accident 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29h. nature and title of certifie

W (10)

State Registrar Lew NARECKER MY ONE
31. Date filed (Month, Day, Year)

APR 3 0 2008

See My Done
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 (7)

m DME

1002428

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 1, ^{Day} 2008 **Physician** Adolfo Schust 11:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glade Valley Nursing & Rehab. Frederick Walkersville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 2, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1**X** M 2□ F Argentina 79 578-56-2644 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show notifled at 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Director MD Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 21793 USA 56 W. Frederick Street Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1X Yes 2 No Specify: Saltimore, Maryland 21215-0036 2 Specify: White 3 Widowed 4 Divorced Argentine Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Painting House Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) in and Mental H Be Bernard Schust Lea Kurland ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Schust Robinson/daugh 2829 Onrado Street Torrance, CA 90503 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Chesapeake Crematory | 05/05/08 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 Aurely L. Heckrotte, P.A. C. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 DWE Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Left Hip Fracture 6 days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner b Alzheimer's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Years Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the. attending properties use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ Chronic Obstructive Pulmonary Disease Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed' certificate 1∐ Yes 2X No or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1X Yes Other: 4 🛛 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2∏ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ☐ Natural 5 Pending investigation ours after death.

neral Director: Al
filled in by the fu 1 ☐ Yes 2 ☑ No 2**X**Accident 04/25/08 A fell 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State56 W. Frederick Frederick, MD determined 4 ☐ Homicide W. Frederick St Nursing Home Frederick, To the Hospital within 24 hours a To the Funeral Completely filled Hospital **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 1, 2008 D26516 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2)00 Frederick, MD 21702 1475 Taney Avenue, Allen J. Gilson, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 0 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:50AM Schae, SUE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deatl Examiner Howard Vantage House Columbia If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Apr 25, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Min 1 ☐ M 2 🔀 F 89 1919 South Carolina Director 216 48 9807 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 □ Yes 2 XNo Director Howard Columbia within 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21044 5400 Vantage Point Road by Funeral 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: 3 ₩Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Alexander Shuford Fannie Gibson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James B. Schaeffer, Jr./Son 1304 Brunswick Drive Eldersburg, MD 21784 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cem. 5-7-2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Immediate Cause (Final disease or condition resulting in death) DEMENTI Physician /Medical Due to (or as a consequence of) Examiner DEBILIT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner requires that the death certificate be executed androwyo burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: ISe 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 2 1 Tyes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 2 - No 25. Was case referred to medical examiner? funeral director. TagE 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 0 this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Division Hospital or Attending 1 Natural Injury thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MAY 3, 2008 053987

16 E.G.

State Registrar

DHMH 17 Rev 1/2001

Suite 34

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2mory

KENNETH GEH, MIS

BALTINONE MD 21201.

			1 = For AMEND#1, perMD, 5 State Registra AMEND#5 per IN	State of 12/08, DPS, N F5/5/08, EW	Marylan 1000 ,MoOo	d / Depa	artment of rtificate o	Health of Death	and M	ental Hy	giene Reg. No.	2008	8 16077
6	Physici	an	1. Decedent's Name (First, Middle,	Last)						2. Date of De Month	ath Day	Year	3. Time of Death
7	/Medic	al	LaFaye Adams Steve			vens	# 01 T		-(Darath	May 1,	2008	country of Door	1:00 A M
	Examir	er	4a. Facility Name (If not institution,		er)		4b. City, Tow		of Death			ounty of Deat	n
<u> </u>	Funeral		Summerville of Pot 5 Social Security Number 578-34-4105	6. Sex 7	Age (In yrs.	last birthday)	Potor If Under 1 Ye	ar If Under		8. Date of Bir	th	tgomery 9. Birt	hplace (State or Foreign
	Director		149-48-1594	1□ M 2∏ F	80	Yrs.	Months Da	ys Hours	Min.	(Month, Da Apr 8,			abama
	w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation						10d. Inside City Limits
	Maryla f sho	ō											1 □ Yes 2 □ No
	r 28a	Directo	Maryland Mont	gomery	Ker	nsingtor	1 10f. Zip Cod	e			10g. Citize	en of What Co	untry?
	th witl 23a o ist be	al D	4917 Strathmore Av	e			20895				USA		
36	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Will Widowed 4 Divorced	12. Was Deced Armed Ford	es? No	ŀ	Was Decedent of the Ves, specify C			cify Yes or No Rican, etc.))- 14	4. Race - Ame Black, White Specify:	e, etc.
ò	2 hou natura ical E	ted	15. Decedent's		- 0		dent's Usual Oc		at at complete		16b. Kind	wn of Business/	iite Industry
21215-0036	- 2 0	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	kind of work do DO NOT use re	tired)	SI OI WOIKII	ig			
	should be filed withir and Mental Hygiene. marked other than matic event, the Me		17. Father's Name (First, Middle, L	4		Но	memaker	19 Moth	or's Nama	(First, Middle		Home	
anc	d be fi	Be	, ,	ast)								urname)	
Maryland	s 1 and 2 should I f Health and Men Item 27 is marke other traumatic	은	Joshua Page Adams 19a. Informant's Name/Relationshi	p (Type. Print)		19b. Maili	ng Address (Str			<u>Kate Lan</u> I Route Numb		Town, State, 2	Zip Code)
	d 2 th a		Gayle Simmons/Daugh	nter		4917 S	trathmore	. Ave. Ke	ensing	ton, MD	20895		
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other		20a. Method of Disposition 1 Burial 2X Cremation	3 □Removal from St	ate	Place of Dispo emetery, cre	osition (Name of matory or other	place)	D	ate	20c. Loca	ation - City or	
Ē	artme ortani injun		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service ▶		/ Fc		oln Crema 2. Name and Ad			, 2008		ntwood,	
ä	Depa Impo any in		ans	A Ven	Jan	1	1800 New	Hampshin	re Ave	, Silver	Spring	g, MD 20	904
	Physician	8 4	23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final	nly one cause on eac	used the death ch line. Hyperten		ter the mode of	dying, such as	s cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	as a consequ								
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	pe #is	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or	as a consequ	uence of):						1	
	and I-tram	Examiner	that initiated events resulting in death) Last	U	Hypothyr as a consequ								
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9	ertifica ling ph e as th	Med	IF FEMALE:										
.O. Box	irres that the death certificate be executed signed by the attending physician and it be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 No 9 ☐ Unknown		th 2 Feta nt at time of d	Ideath 3[□Ectopic pregna □ Other (specify				23	3d. Date of del Month	livery Day Year
Δ.	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant condition	s contributing to dea	th but not resu	ulting in the u	nderlying cause	given in Part	I.	23e. Did	obacco us	e contribute to	the cause of death?
ıd	w require been sig should b	ed b	****							1 🗆	Yes 2□	No 3□P	robably 4 ⊠Unknown
Records,	e + e	Completed						·			psy ormed?	prior to death?	utopsy findings available completion of cause of
Vital	iclan: Th certificate ector, pag	Be Co	25. Was case referred to medical		_			26. Plac	e of Death	1 Yes (Check only		1 □ Yes	
>	Physiclan: this certific	To B	examiner? 1 ☐ Yes 2 ☐XNo	Hospital: 1 Ing	oatient 2 🗌	ER/Outpatie	nt 3 DOA	Othor				Other (Spe	Assisted city) Living
on or	fter Ter		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga		Injury Day Year)	28b. Time o Injury		njury at Work? I □ Yes 2 □		8d. Describe	how injury	occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident Investige 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place o	f injury - At ho g, etc. <i>(Specif</i>	ome, farm, sti	reet, factory, offi				Street and wn, State)	Number or Ri	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical (29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical E	Physician: To the be xaminer: On the bas and manne	is of examina	wledge, deat tion and/or in	th occurred at the	e time, date a ny opinion, de	and place, a	and due to the ed at the time	cause(s) a , date and p	and manner as place, and due	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		_		29c. Lic	ense number			29d. Date	signed (Mont	th, Day, Year)
	1		h	ecc-			DO	064578			May	1, 2008	
	7		30. Name and address of person w		·								
	Sta	te	Mehmooda Naeem, MD 31. Date filed (Month, Day, Year)	15225 Shad	y Grove gistrar's Signa	Rd, Sui	te 208, R	ockville	e, MD 2	20850			
	Registr		31. Date filed (Month, Day, Year) MAY 0 2	2003	gistrar's Signa	1 A	self!						

State of Manyland / Department of Health and Mental Hygiene

		1	For State	State of Maryl		rtificate of L			leg. No. 🗀 🥤	100	15070		
	W 5000		Registrar Decedent's Name (First, Middle, Last)			timouto or a		2. Date of Dea	th	100	3. Time of Death		
	Physicia	ın	Masoud		Shahidi			Month April 2	9, 2008	Year B	4:40 pm M		
	/Medic Examin	and the	4a, Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death	in.		ty of Death	•		
	Examin	₽I.	516 White Surf Te	rrace		Gaithei	sburg		Mont	gomery	y .		
1	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	place (State or Foreign		
	Director		218-92-4670	M 2□F 7	5 Yrs.	World 5 Days	Tiours William	OCT 9,	1932	Iran			
40	P.		Usual Residence of Decedent	100	. City, Town or Lo	ocation					10d. Inside City Limits		
	inylar show fat	_	10a. State 10b. County								1 □Yes 2X No		
	Ba-f s	9	Maryland Montgome:	ry (Gaithers				10g. Citizen o	1 M/hat Cau	ntn/?		
	or 2	Directo	10e. Street and Number			10f. Zip Code			Unite				
	ath w		516 White Surf Te		- LLC 12	20878	ionania Origin? (Sn	pecific Ves or No-		ace - Ameri			
	er de Items	Funeral	11. Marital Status 1 □ Never Married 2X Mamied	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 X No	110.5.	Was Decedent of H If Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	В	ack, White,			
36	s aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Spec	ify: W	nite		
Ş	filed within 72 hours after death with the Maryland Hygiene. Hhysiene. Hister than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	pa	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation		16b. Kind of	Business/Ir	ndustry		
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212	with yiene r tha	E	Elementary/Secondary (0-12)	5+	Sales	s Manager					ig Sales		
פ	other other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surn	ame)			
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ary	should be mad in the man		19a. Informant's Name/Relationship (Ty	rpe. Print)	19b. Mail	ing Address (Street	and Number or Ru	ral Route Numbe	er, City or Tow	n, State, Zi	ip Code)		
Σ	s 1 and 2 of Health a item 27 Is other tra	- 3	Mahin Shahidi / W			White Sur							
ore	of He of Her	3	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F			osition (Name of ematory or other plac		Date	20c. Locatio	•			
Ĕ	Pagenent Inent Inny o		4 □ Donation 5 □ Other (Specify)	(Heaven Ce					ng, MD		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked out Hygiene. Instruction: If item 27 Is marked out the than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens		F	2. Name and Addre Thibadeau	ss of Facility Mortuary	Servic	e, P.A				
_	207 = 20		fru f/all		1956	933 Gist <i>A</i>	Ave., LL,	Silver	Sprin	g, MD			
	A AND 1887		23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
	Physician	ï	Immediate Cause (Final disease or condition CARCINOMA OF STOMACH										
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	± 00 €		IF FEMALE:	23c. If yes, outcome pf p					23d.	Date of deli	very		
Вох	death cer e attendin d for use	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		☐Ectopic pregnanc ☐ Other (specify) _	у			Month	Day Year		
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	w requires that the d been signed by the should be detached		Part II. Other significant conditions co	ontributing to death but no	ot resulting in the	underlying cause giv	ven in Part I.	23e. Did t	obacco use c	ontribute to	the cause of death?		
or Vital Records,	requires that een signed b nould be deta	d by						1 🗆	Yes 2 No) 3 □ Pro	obably 4 Xunknown		
00	w rec	Completed						24a. Was		b. Were au	topsy findings available completion of cause of		
Be	The law ate has b page 2 st	Ĕ						auto perfo 1⊟ Yes	rmed? 2 🔼 No	death?	-37		
ta			25. Was case referred to medical				26. Place of Dea	ath (Check only					
5		To Be	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient	2 ER/Outpation	ent 3 DOA Oth	ner: 4 Nursing H	lome 5X Resi	idence 6 🗆	Other (Spe	cify)		
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Division	or Atten after deatl Director: in by the	iji	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - building, etc. (S	At home, farm, s	street, factory, office			Street and Nu wn, State)	ımber or Ru	ıral Route Number,		
	tal or s afte al Dir ed in	Certification:	_ /)										
	To the Hospital or At within 24 hours after do To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Exam	ysician: To the best of more best of more basis of example basis of example basis of example best of example b	amination and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occ	e, and due to the urred at the time	cause(s) and , date and pla	manner as	s stated. e to the cause(s)		
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	5 with	Σ	29b. Signature and title of certifier	160	10		64615		MAY 3				
	6		John Wi	Com									
			30. Name and address of person who of GENEVIEVE WROBLEV				VE. SHTTE	E 100. R	OCKVTL	LE. M	D 20850		
,	^ <u>C</u>	ate	31. Date filed (Month, Day, Year)	32 Registrar's	Signature		, 00111	_ 100, K					
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			For State	State of Ma	iryland		rtmen			and M		iene eg. No. 🤌	n a		0.79
-			Registrar 1. Decedent's Name (First, Middle, L	ast)							2. Date of Dear	h	000	3. Time o	f Death
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	/Medic	to white	4a. Facility Name (If not institution, g		00111		4b. City,	Town, or	Location of	of Death		4c. Cour	nty of Death		
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a .	Funeral			Sex 7. Age	(In yrs. last	t birthday)		1 Year Days			8. Date of Birth (Month, Day			olace (State	or Foreign
	Director		219-38-1304	1 □ M 2 🔀 F	79	Yrs.	IVIOITUIS	Days	i louis		May 11,		_	rmany	
-	TO O		Usual Residence of Decedent		10c. City, T		4:						1	10d. Inside (City Limits
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	or 28	Dire	10e. Street and Number				10f. Zip							_	
	after death with the Maryland or items 23a or 28a-f show miner must be notified at	by Funeral Director	19045 Canadian C			101	Mar. D	208		ining (One	situ Van ar Na		ed Sta Race - Ameri		
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3	hour tural ai Ex		15. Decedent's		1	16a. Dece	dent's Usu	al Occupa	ation			16b. Kind o	Business/Ir		
215-0036	in 72	Completed	(Specify only highest of	grade completed)		(Give life.	kind of wo DO NOT u	rk done d se retired	during mos)	st of worki	ng				
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ס ס	be filed within 72 hours after death with the Marylan and Hygiene. All Hygiene. All Hygiene. All Hygiene is the medical Examiner must be notified at event, the Medical Examiner must be notified at		17. Father's Name (First, Middle, La	st)					18. Moth	er's Name	(First, Middle,	Maiden Suri	name)		
yland	d be ental ked c	To Be	Philip	Gaa							Else_	Horn	ig		
2	nd M mar mar	-	19a. Informant's Name/Relationship			19b. Maili	ng Address	(Street	and Numb	er or Rura	al Route Numbe	r, City or To	wn, State, Zi	p Code)	
Mar	alth a		Max Joseph Schmi	tt/Husband		19045	Cana	dian	Cou	rt, M	lontgome	ry Vi	llage,	MD.	20886
<u>6</u>	permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If Item 27 is marked of any injury or other traumatic ever once.		20a. Method of Disposition		20b. Plac	ce of Dispo	osition (Name	ne of other plac	e)		Date	20c. Location	on - City or T	own, State	
6	ent o ent o nt: If		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				s Cem		1	May 5	,2008	German	ntown,	Mary	land
Baltimore,	artm ortar injur		21. Signature of Funeral Service Lice	- /	0(7 2	2. Name a	nd Addre			701 Fune				
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p,			23a. Part1. Enter the disease, or co	mplications that caused	the death.	Do not en	ter the mo	de of dyir	ng, such as	s cardiac	or respiratory ar	rest,		Approxim Interval B	ate etween
	Physician		shock, or heart failure. List or Immediate Cause (Final			1 U.m	orrho	100						Onset and	d Death
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	Examiner			b. Hyperte	nsion										
E	ATT THEY	ĕ	Sequentially list conditions, it my cause. Enter Underlying Cause (Disease or injury	Due to (or as		nce of):							_		
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1200	e X e	Sa		d Cerebro	vascu	lar A	ccide	ent							
89	The law requires that the death certifica the has been signed by the attending phoage 2 should be detached for use as the	Jed	IF FEMALE:												
Вох	death certifical attending phase as t	Physician/Med	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐Live birth			□Ectopic p	regnanc	y			23d.	Date of deli Month	very Day	Year
	dea ne att	sici	in the past 12 months? 1 ☐ Yes 2 🖾 No	4□Pregnant a 9□Unknown	t time of dea	ath 5	Other (s	pecify) _						,	
<u>Р</u>	at the de by the	h	9 □ Unknown			ilia — Im Alban a	un do duin a		on in Bort	· I =	23a Did t	phacco use i	contribute to	the cause of	of death?
	res that signed to be det	by	Part II. Other significant condition	s contributing to death it	out not result	ang in the t	undenying	cause giv	eninran	. 1.			lo 3 □ Pro		
ğ	w require s been sig should b														_
Vital Records,	has be	ble									24a. Was autoj		4b. Were au prior to death?	topsy finding completion o	gs available f cause of
<u> </u>		Completed									1⊟ Yes	2K No	1 ☐ Yes	2□ No	
ita	Physician: The this certificate har director, page	Be (25. Was case referred to medical examiner?					100		ce of Deat	th Check onl	one			_
	ys Gi	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati			ent 3 D	٠٨		Nursing Ho	ome 5 Resi			cify)	
Division or	ng Pl		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inj (Month, Da		28b. Time Injury		28c. Inju Wo		ا ۱۰۰۰	28d. Describe	now injury o	ccurrea		
000	Attending Ph or death. rector: After th by the funeral	äti	2 ☐ Accident investiga	ition			M		Yes 2	7140	28f. Location (Street and A	lumbar or Pu	iral Pouto N	lumber
Ž	i or Att after de Direct	Certification:	3 Suicide 6 Could no 4 Homicide determin		tc. (Specify)	ne, rarm, s	treet, facto	ry, office			City or To		amber or ric	1121 110010 14	ambor,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		00 0 00 00	Physician: To the best	t of mu know	dedge des	ath coourre	d at the t	ime date	and place	and due to the	cause(s) an	d manner as	stated.	
	Hosp 4 hot Fune tely fi	Medical	29a. Certifier 1 X Certifying (Check only 2 Medical E	xaminer: On the basis	of examination	on and/or	investigation	on, in my	opinion, d	eath occu	rred at the time	date and pl	ace, and due	to the caus	se(s)
	thin 2 the the mplet	Med	one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (i									igned (Mont	h, Day, Year	r)	
	T V V	-	Jina G	int,				ъ	/, 110	. 2		36	. 1 04	000	
•	di				donth (line-	22a) (Tue-	Drint\	ע	4116	14		Мау	1, 2	UUB	
	()		30. Name and address of person w					rm c r	torm	Mar	vland ?	0874			
		ote	Vinu Ganti, M.D. 31. Date filed (Month, Day, Year)	2. Regist	trar's Signatı	ure		rman	∟UWII.	rial	yranu Z	0074			
	St Regist	ate trar	MAY 0 2 2	409	. 1	Rose	1								

Ronald Allen Sis		1- For State Registrar	Sta	ate of Maryl			ment of i icate of i			Menta	al Hyg		Reg. No.	20	0.8	1608
Physicia Medical Examin	an/	1. Decedent's Name	e (First, Middle Allen	e,Last) Sis k							l i	Date of Dea Month April 29, 2	Day	Year	3	Time of Death 1940 hrs
		4a. Facility Name (i	if not institution	n, give street and r	number)		41	City, To	wn, or Lo	ocation of		710111 20, 1	4c.	County of De	ath	
Funeral		13038 Mills 5. Social Security N		6. Sex	7. Age (In	vrs. last b	birthday)	Lusby If Under	1 Year	If Under	24Hrs.	8. Date of B		alvert OD/YYYY) 9.	Birthp	lace (State or
Director		217–96–4947		1 M 2 F		,	Yrs.	Months	Days	Hours	Adim	July 28		ÎFo	reign	try.Washington I
any	Ì	Usual Residence of	f Decedent 10b. County		10c	City. Toy	wn or Locatio	n							1	0d. Inside City Limits
* .	_	Maryland	Calvert		I	usby										Yes 2 X No
Maryla r 28a-f	Director	10e. Street and Nur 13038 Mi		k Drive		-		10f. Zip 0					_	zen of What C ad State		P
death with the Maryland or items 23a or 28a-f sho		11. Marital Status		12. Was D	ecedent Eve	r in U.S.		Deceden	of Hisp			cify Yes or N		14. Race - Ar	nerica	n Indian, Black,
	Funeral		ed 2 X Ma	1 Yes		No					Puerto R	tican, etc.)		White, et	c. Wahi	ite
urs afte tural",	ē	3 Widowed 15. Decedent's Ed		or Dates: bify only highest gr		ed) 16	ia. Decedent		ccupatio	n (Give ki				Specify: (ind of Busine	ss/Inc	lustry
36 nin 72 ho e. than "na dical Ex	Completed	Elementary/Second 12	indary (0-12)	College	(1-4 or 5+)	S	during mo upervis	st of worki	ng life. I Cilit	ies m	einta	ance	U.	U.S. Government		ent
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once	Be Com	17. Father's Name Robert How			· ·. ·-					3.Mother's /irgi n		First, Middle	, Maiden	Surname)		
212 thould b nd Men is marl	유	19a. Informant's Na		nip (Type, Print)		2242			-				ımber, Ci	ty or Town, S	tate, Z	ip Code)
e, MI and 2 s Tealth a item 27		Melissa Sis 20a. Method of Dis	position			20b. Plac	P.O. Bor ce of Disposit matory or other	ion (Name	of cem	etery.		20685 1988	20c. I	Location - Cit	y or To	own, State
Baltimore, permit. Pages I as Department of He Important: If ite			Other Sp	3 Removal	from State	Metro	natory or othe politan	er place) Funer	al Se	rviœ		2000	Ale	exandria	Vi	rginia
Baltimore permit. Pages 1 Department of H Important: If i		21. Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Ts. Rd. Port Republic, MD 2067										6				
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death				
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot Wound of Head Due to (or as a consequence of):											Death			
= '	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):															
	Examiner	cause. Enter Under (Disease or injury t	erlying Cause that initiated	c. Due to (or as	a conseque	ence of):									4	
), be executed sician and urial - transit		events resulting in	death) Last	d												
	ledical	UNPENDED		AMENDE		f nzaznan							1 22	d Date of del	iven	
Ox 687(eath certifica e attending ph for use as the	Physician/M	IF FEMALE: 23b. Was decedent past 12 months 1 Yes 2 I	s?	1 Live	s, outcome o birth gnant at time th known		2 Fet	al death er (Speci	3 [fy)	Ectopic	pregnan	псу	230	d. Date of del Month	Da	y Year
P.O. B is that the de gned by the e detached i	by Ph	Part II. Other signi	ficant condit			t not resu	lting in the u	nderlying	ause gi	ven in Par	t I.			_		ne cause of death?
ords, P.C w requires that is been signed should be dete	ted t											24a. Wa				bly 4 Unknown ppsy findings available
ecor ne law r te has b ge 2 sho	Completed											per	opsy formed? s 2 ✔ N	deat		mpletion of cause of
Vital Rec ysician: The l his certificate l	Be	25. Was case refer examiner?	red to medica					26		of Death (Check o					
of Vit	ပ္	[2 No	Hospital:	Inpatient te of Injury	1 28	R/Outpatient		<u>^^</u>	Other4		Home 5 28d. Describ		ury occurred	Other:	Scene
sion of trending Pi death ctor: After y the funera	tion	1 Natural	5 Pend	_{lina} FOUR	nth, Day, Year) ID: 9, 2008	F	OUND: 728 hrs	,,		es 2 🗸		Subject sh				
Division of Vital Records, spinal and require hours after death neural birector: After this certificate has been siy filled in by the funeral director, page 2 should be filled in by the funeral director, page 2 should be	Certification:	2 Accident 3 Suicide	6 Coul	d not be 28e. Pl		- At home	e, farm, stree	t, factory,	office bu	iilding, etc	- 1	or Town.	State)	and Number of		al Route Number, City
Di To the Hospital within 24 hours a To the Funeral	Medical Ce	4 Homicide 29a. Certifier (Check only one) 2		nysician: To the b miner:On the basi	est of my kn	owledge,	death occurr				ce, and	due to the ca	use(s) ar	nd manner as	stated	
To with To con	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,							h, Day, Year)							
		O.C.M.E. April 30, 2008														
RW 10		30. Name and addr Laron Locke		who completed ca ssistant Medio			^{Ba)} 111 Penn	Street,	Baltim	ore, MI	2120	01				
	ate	31. Date filed (Mon	MAY Year)	5 2008 32.	Registrar's S	· A	K Son	relle s								
Regisi	11.1					-	77 10 4	-								

OCME

State of Maryland / Department of Health and Mer 1- State Certificate of Death		0000 10001
- negistrat	Reg. N	3. Time of Death
		Ol 2008 0533 M
/Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death
CENTIALSULA PEREDUAL MED CENTER SALISBURY		Wicomico
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I ff Under 24 Ars. 8.	Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
Director 222-10-8312 83 Fe	b. 24, 19	Delaware Delaware
D Osdai Nesiderice di Decederit		10d. Inside City Limits
O TO THE STATE OF		1 ☐ Yes 2 ½ No
The state of the s	10g. (Citizen of What Country?
DE Sussex Delmar 10c. City, Town or Location DE Sussex Delmar 10c. Zip Code 11221 Line Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Cuban Mexican Plants Bid.) 14. Was Decedent Ever in U.S. 15. Was Decedent of Hispanic Origin? (Specify Cuban Mexican Plants Bid.)		U.S.A.
11221 Line Road 19940 11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify, If Yes, specify Cuban, Mexican, Puerto Rick 12. Was Decedent Ever in U.S. Armed Forces? 18. Was Decedent of Hispanic Origin? (Specify, If Yes, specify Cuban, Mexican, Puerto Rick 12. Was Decedent Ever in U.S. Armed Forces?	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.
y set to		Specify: white
Second Se	16b.	Kind of Business/Industry
(Specify only highest grade completed) College (1-4or 5+)	- 1	
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working like DO NOT use retired) Research & Development 12 15. Decedent's Education (Give kind of work done during most of working like DO NOT use retired) Research & Development Technical Assistant		Nylon Company
フロック 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Middl		en Surname)
The lma lead of the latter of		v or Town State Zip Code)
Thelma Jean Smith (Wife) 11221 Line Road Delma		19940
		Location - City or Town, State
20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home	2008 Heb	oron, Maryland
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13. Fract Crosse		•
13 East Grove Street	: Delm	nar, DE 19940
23a. Part1. Enter the disease, obscimplinations that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.	espiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (classes of injur)		
fi any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Coupe (Ciscaes of Figure that initiated events resulting in death) Last Due to (or as a consequence of):		4
ত ভূ ব ব ব ব ব ব ব ব ব ব ব ব ব ব ব ব ব ব		
dical file of the principle of the princ		
The first initiated events of the property of that initiated events of the property of the pro		23d. Date of delivery
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		Month Day Year
O et the depth of the significant conditions contributing to death but not resulting in the underlying cause given in Part I		
O of the first of	23e. Did tobaco	co use contribute to the cause of death?
SI Records, The law requires t cate has been signe page 2 should be completed by Completed by	1 ☐ Yes	2 No 3 Probably 4 Nhknown
Aecc	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
The page	performed 1□ Yes 2□	? death?
The second of th		
O 1 Yes 2 No Hospital: 1 Inpatient 2 PER/Outpatient 3 DOA Outper: 4 Norsing Home 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28c	5 ☐ Residence d. Describe how i	e 6 Other (Specify)
27. Manner of Death 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No 1 Accident investigation		njarij oddariou
The plant of the p		t and Number or Rural Route Number,
De la	City or Town, S	iate)
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number		
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number		
29b. Signature and title of certifier 29c. License number	290.	Date signed (Month, Day, Year)
De Churchen P309/2		5/1/08
30. Name an address of person who completed cause of death (Item 23a) (Type, Print) Denhis Chadnicki 100 E. Carrol 1 St., Salisbury, Md. 21801		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		

Registrar
DHMH 17 Rev 1/2001

MAY 0 1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2008 4:30 April A Elena Vinokouroff Tidwell /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Laurel Regional Hospital Laurel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 👿 F Yrs 12, 1926 Washington, DC Director August 579-34-0764 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show idical Examiner must be notified at ¶∑Yes 2 No Director Prince George's Laurel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20707 United States 7607 Stratfield Lane Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🔀 No Specify: White 9 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than t Elementary/Secondary (0-12) College (1-4or 5+) Government Clerical 12 should be filed what and Mental Hygier 12 warked other the contract of the 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ever Anastasia Yakushkova Michael Vinokouroff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7607 Stratfield Lane Laurel, MD 20707 Alice Tyson Tidwell/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Maryland Nat'l Mem Pk May 1, 2008 Laurel, MD Donation 5 Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. ature of Fundam L Service Liverse 21. Sig 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 Congestive Heart Failure years **Physician** /Medical Due to (or as a consequence of): **Examiner** 10 years Advanced Atherosclerosis Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of/r Examiner Peripheral Vascular Disease 5 years burial-trai Due to (or as a consequence of): Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe death? 1 □ Yes 2□ No 1□ Yes 2 TKNo 25. Was case referred to medical examiner? 26. Place of Death Check onl one director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 km ER/Outpatient 3 DOA P 28b. Time of funeral 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Injury 1X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide

law requires that the death certificate be executed Box 68760. attending phase as the P.O. ed by the a Division or Vital Records, has certificate this

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

and physician After Director:

Hospital or Attending 24 hours after death. n 24 hour the Funeral Dire 2

5

31. Date filed (Month, Day, Year) State APR 3 0 2008 Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

D13671

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

April 28, 2008

30. Name and add ss of person who com ted cause of death (Item 23a) (Type, Print) 14201 Laurel Park Dr. Laurel, MD 20707 B.G. Manejwala, M.D.

32. Registrar's Signat

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 APRIL 7:37 A M THOMAS EDWARD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S FORT WASHINGTON 6900 IGNATIUS ROAD # 304 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. | FEB 27 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 XM 2 □ F WASHINGTON, DC Director 217-60-8764 55 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No FORT WASHINGTON PRINCE GEORGE'S MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20744 6900 INGATIUS ROAD # 304 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ∑\No tf Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🛣 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) the PRIVATE MAINTENANCE TECH. 12th permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygin Important: If item 27 is marked other eary Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RUTH WILKINSON EDWARD E. THOMAS SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20785 1909 VERMONT AVENUE CHEVERLY, MARYLAND ARLENE WOODS/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cre 3 ☐Removal from State 4 □ Donation 5 ☑ Other (Specify) HARMONY CEMETERY 5/5/2008 LANDOVER, MARYLAND Signature of Femeral Service Lense 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): **Examiner** RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2【 No 24a. Was an page 2 autopsy performed?

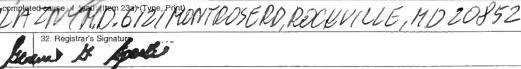
1 Yes 2 No certificate Physician: completely filled in by the funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 TXNo 1 ☐ Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) m.o. 04-29-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IHN W. ROH M.D. 5107 SILVER HILL ROAD SUITLAND, MARYLAND 20746 31. Date filed (Month, Day, Year) 32. Registrar's Signa State APR 3 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last), **Physician** 2001 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY HEBREW HOME ROCKVILLE 8. Date of Birth (Month, Day, Year) NOV. 12 1956 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1□M 2 F WASHINGTON, DC 579-80-1828 51 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ns 23a or 28a-f shov must be notified at 1 XYes 2 No Director MONTGOMERY MD ROCKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6105 MONTROSE ROAD RM 4187B 20852 IISA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or item edical Examiner r Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ž No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced d other than "natura event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT ADMINISTRATIVE ASST. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental 27 is marked of traumatic even MARGARET PHILLIPS FREDERICK TENEYCK ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 CHANALE TAYLOR/DAUGHTER 2905 ROSE VALLEY DRIVE FT. WASHINGTON, MARYLAND 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Itel any injury or otl 1 ☐ Burial 2 Macremation 3 ☐ Removal from State RIVERDALE CREMATORY 5/1/2008 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. List BELLAR DEGENERATI Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 After this 27. Many fer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: Injury 1 Natural 5 Pending investigation s after deam. 1 Tyes 2 🗌 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

31. Date filed (Month, Day, Year. APR 3 0 2008

29b. Signature and



D39436

29d. Date signed (Month, Day, Year)

APRIL 26, ZOOS

			1 - State Registrer	State of Maryla		artment of I			giene Reg. No.	008	160	86
	Physici		1. Decedent's Name (First, Middle, Last) Stanley L	angston T	homas			2. Date of De Month April	Day	2008	3. Time of E	Death M
	/Medic Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	or Location of I			ounty of Death		
n'		2	Calvert Memori		1	Prince			(Calver	t	
	Funeral Director			7. Age (In yr	s. last birthday) 4 Yrs.	If Under 1 Year Months Days		Min. 8. Date of Bird (Month, Da A P r • 4	1°9'34	4 9. Birth	place (State or ntry)	Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation					10d. Inside City	Limits
	Mary Fi eh	tor	MD Calver	t	Pr	ince Fr	ederi	ck			1 ☐ Yes	2 🔀 No
	with the 3a or 28s	i Direc	10e. Street and Number 215 Hallowing	Point Road		10f. Zip Code 206	78			n of What Cou	ntry?	
0000	ges 1 and 2 should be filed within 72 hours after death with the Maryland to of Health and Mental Hygiene. It of Health and Mental Hygiene. or other treumatic event, the Marchall Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ∰ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of I		n? (Specify Yes or No Puerto Rican, etc.)		Race - Amer Black, White	etc.	
5	2 hou	ted	15. Decedent's Edu	cation	16a. Deced	dent's Usual Occu	pation		16b. Kind	of Business/li	ndustry	
21717	y within 7 jiene. r then "r	Completed	(Specify only highest grade Elementary/Secondary (0-12) 1 2	College (1-4or 5+)		kind of work done DO NOT use retire f Crewm		of working	Sai	nitati	on	
	uld be filed flental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Calvin	Thom	as			s Name <i>(First, Middle,</i> estine		eeland		
ary	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (Ty)					or Rural Route Number				
2	l and Health Im 27 her tr		Marine Thomas/w				ng Pt	. Rd. Pr				0678
5	ages nt of the :: If ite		20a. Method of Disposition 12 Burial 2 □ Cremation 3 □ R	amoval from State		natory or other pla		Date / 5 / 2008		ition - City or T		4D
Dallillor	permit. Pages 1 an Depertment of Heali Important: If Item 2 eny injury or other once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		22	. Name and Addre	ess of Facility	Sewell F	ınera	al Hom	e, P.A	4D
	ac z • a		23a. Part 1. Enter the disease, or compli	cations that caused the de				ach Rd.		ce rre	Approximate	
	Physician /Medical Examiner	Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitiated events	Due to (or as a cons	equence of): HROMA	T0315					Interval Betw Onset and De	
00/00	The law requires that the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical	resulting in death) Last	Due to (or as a cons	equence of):							
0.00	i that the death certific ted by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	Ectopic pregnanc Other (specify)	у		23	d. Date of deliv Month	,	ear .
cords, r	quires that n signed by	þ	Part II. Other significant conditions con	ntributing to death but not r	esulting in the u	nderlying cause gr	ven in Part I.		obacco use		the cause of de	eath?
		Completed						24a. Was autoj perfo 1 🗆 Yes		prior to c death?	opsy findings a ompletion of cal	vailable use of
Vila	sician certifi rector	Be	25. Was case referred to medical examiner?	lospital:		_ [0:	han	f Death Check only o	1217			
5	ling Phys 1. After this funeral di	ion: To	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Inju	ry at	28d. Describe			fy)	
DIVISION	To the Hospital or Attending Physician: within 24 hours alter death To the Funeral Director: After this certifici completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Albuilding, etc. (Spe	t home, farm, str ccify)]Yes 2⊡No	28f. Location (. City or Tot		Number or Ru	al Route Numb	ΘΓ,
	le Hospit n 24 hours le Funera letely fille	edicai C	29a. Certifier 12 Certifying Physical Control (Chack only one)	sician: To the best of my k ner. On the basis of exami and manner stated.	nowledge, death	h occurred at the ti vestigation, in my	ime, date and i opinion, death	place, and due to the occurred at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)	
	To th To th comp	Me	29b. Signature and title of certifier) /		29c. Licen	se number			signed (Month		
			fletin	nul_	- MD	D4	0370)	4,	130/0	8	
ZiL	7+1			WSKI, M.	em 23a) (Type,	Print	e Fra	ederick,	MO	206	78	
	Sta Registr		31. Date filed (Month, Day, Year) APR 3	32. Registrats Sig	nature	Sperk	9	,				

Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: filled in by

Saltimore, Maryland 21215-0036

10+ Registrar

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

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Deal 0 Church ton

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

32. Registrar Signature

ORIGINAL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Road

7) 50653

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GYAN .

29d. Date signed (Month, Day, Year)

SURANA

5-1-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year John P. Temple, Jr. nau 2112 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Wicomico lisbury Rehab + Nursing Ctr. alisbur 8. Date of Birth (Month, Day, Nov. 12, 9. Birthplace (State or Foreign 5. Social Security Number, Days 1 X M 2 □ F Louisiana 75 Nov. 175-28-0407 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Salisbury Maryland Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21801 26968 Nanticoke Road USA 12. Was Decedent Ever in U.S. Armed Forces? Years 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. Ti Myes 2 □ No If Yes, Give Unknown Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bale Handler Paper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John P. Temple, Sr. Charlotte Coleman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26968 Nanticoke Road, Salisbury, MD 21801 Ella Temple/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 Removal from State 5/17/2008 West Chester, PA R.A. Ferris & Co. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, MD 21802 Approximate Interval Between Onset and Death Pagh. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseque Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 9☐Unknown Month Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an eutonsy 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner Examiner The law requires that the death certificate be executed

permit. Pages 1 and 2 Department of Health a Important; If Item 27 is any injury or other trai once.

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f shormust be notified at

or items 23a

ent, the Medical

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite

Maryland 21215-0036

Baltimore, |

Division or Vital Records, P.O. Box 68760,

or Attending Physician;

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Director

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attending physician and for use as the burial-transit signed by the a d be detached f Director: A

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After this

within 24 hours at To the Funeral C Hospital

Physician/Medical

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Completed

Be

Certification: To

Medical

IF FEMALE:	
23b. Was decedent pregnant in the past 12 months?	ì
1 ☐ Yes 2 ☐ No	
9 ☐ Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 27. Manner of Death 1 Anatural 5 Pending 2 Accident 3 ☐ Suicide

4 Homicide

investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes

2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

Dalisburu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Robins, M.D. William 2000 31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Olga Jones Tubman May 1:30 a.^M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Cambridge Dorchester Mallard Bay Care Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F 217-26-1444 Director 82 June 28, 1925 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Y☐Yes 2☐No MD Director Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 411 Edlon Park 21613 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify à Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ogle Z. Jones Roberta Powley ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William W. Tubman Sr. husband 411 Edlon Park, Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot once. Burial 2 ☐ Cremation 3 ☐ Removal from State Christ Churchyard 5/4/08 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD 21. Signature Ineral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD longe 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician tastat MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any sealing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Ses 2 No 3 Probably 4 Unknown USTEOROFOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CANCOR Early Demen page 2 s autopsy perform 1∐ Yes 2100No 1 ☐ Yes 2 100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Accident (Month, Day Year) 5 Pending investigation 1 🗌 Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical

To the Hospital or Attending Physician: hours after death.

Ineral Director: After this y filled in by the funeral di within 24 hours a To the Funeral I

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and add ess of person Street Cambridge

State Registrar

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Date file

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** Fred Henry Trout, Jr. 0704M 2008 Mai /Medical Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Warrowal Wicomico Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Sex 12XM 2□F Months Days Hours Min. 61 Director 218-48-7239 Oct. 2, 1946 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or items 23a or 28a-f show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, the Medikal Examiner must be notified at 1 X Yes 2 □ No Director Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Center Street 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook Private Club Baltimore. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Henry Trout, Sr. Mary Lombardo ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida Somers/Aunt 109 Center Street, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 5/2/2008 Delmar, Delaware 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, MD 21802 Furth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one excuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** AICUD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine certificate be executed that initiated events and bunial-trar resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1☐Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. detached ☐Yes 2☐No the 9□Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ş 1 Yes 2 No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy After this certificate 1 202 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ဥ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 R Naturai Injury 2 🗌 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 TYes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

one)

29b. Signature and ti

of c

Snyder 100 E

30. Name and address of person who

Registrar

29c. License number

(H5049)

29d. Date signed (Month, Day, Year)

5/1/08

and manner stated

Carroll St.

completed cause of death (Item 23a) (Type, Print)

SALis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:00 PMM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 107 BAY VIEW GRASONVILLE OUEEN ANNE'S If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1**X**M 2□ F Yrs. MAY 19, 1929 WASHINGTON, D.C. 78 Director 577-32-5747 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director MARYLAND QUEEN ANNE'S **GRASONVILLE** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or other than "natural", or Items 23a UNITED STATES 107 BAY VIEW 21638 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1946—1948 1 ☐ Never Married 2 ▼ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSUMER ELECTRONICS 10 SALES REPRESENTATIVE permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg. Important: If item 27 is marked other any Injury or other traumonic. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ERNEST JOSEPH THOMAS, SR. MAUDE BRAY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNE LUCILLE THOMAS/WIFE 107 BAY VIEW, GRASONVILLE, MARYLAND 21638 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition APRIL 1 ☐ Burial 2 Tremation 3 ☐ Removal from State CHESAPEAKE CREMATION STEVENSVILLE, MARYLAND 4 □ Donation 5 □ Other (Specify) 2008 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106_SHAMROCK ROAD, CHESTER, MARYLAND 21619 ne disease, or complications failure List only one cause 23a. Part1. Enter shock, or hear Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed that initiated events burial-trai resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No ed by the a 9□Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 Yes 2 No Completed been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be No Hospital: 4 ☐ Nursing Home ို 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) 5 Residence After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Manner of Deatl Certification: 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2∏No death. 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

P.O. Records, Division or Vital Hospital

Director filled n by aiter within 24 hours a

State Registrar

Medical

4 Homicide

(Check only one)

29b. Signature and t

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month; Day, Year)

08-02962 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Steven P. Williams 1. For State Registrar Amend#10c. PerFHPGC4-30-08extificate of Death 2. Date of Death 3. Time of Deatl 1. Decedent's Name (First, Middle, Last) Physician/ Year Month Day April 15, 2008 2047 hrs ¬I Examiner STEVEN PAUL WILLIAMS 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Clinton Suratts Road at Brandywine Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Linder 1 Year **Funeral** Country) Wash Hours D.C. 01-02-80 Director 28 215-02-2347 1X M 2 F Yrs. Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a State Fort Washington 1 X Yes 2 No Washington Maryland Prince Georges Fort or 28a-f show Pages I and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. 23a or 28a-f shorn notified at once, Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20744 1130 Centennial Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 2X No Yes Black Yes 2 X No specify: Specify: If Yes. Give Year 3 Widowed Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Appliance Repair Tech. Appliance Sales 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paula D. Williams Charles Howard, Jr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wash. MD 20744 1130 Centennial Dr. Ft. Baltimore, MD Paula D. Williams/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State 04/24/08 Clinton, MD Department of Important; I Resurrection Cem. Donation 5 Other Specify: 22. Name and Address of Facility Strict an unera ervices 21. Sign ture of Funeral Se . Licensee 6500 Allentown Rd. Camp Springs, MD20748 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hysician Between Onset and failure. List only one cause on each line. Death **Medical** a. Stab Wound of Back Immediate Cause (Final disease _xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit To the Hospiral or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED g physician a the burial -UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death signed by the attending be detached for use as t 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Part II. Other significant conditions 1 Yes 2 V No 3 Probably 4 Unknown þ Completed ficate has been si , page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 2 No 1 🗸 Yes ✓ Yes 2 certificate 26.Place of Death (Check only one) director, 25. Was case referred to medical Be examiner? Other; Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes ဥ No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death Certification: Subject stabbed FOUND: 1 Natural Yes 2 🗸 No neral Director: / Pending Apr 15, 2008 2006 hrs Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Suratts Road at Brandywine Road, Clinton, MD Suicide within 24 hours at To the Funeral D determined (Specify) Woods 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 16, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD.

State Registrar 31. Date filed (Month, Day, Year) APR 3 0 2008 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Margaret Mae Webb /Medical 2008 10:45 a April 28 **Examiner** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Crofton Convalescent & Rehabilitation Crofton Anne Arundel 8. Date of Birth (Month, Day, Year) Sept. 26,1919 West Virginia If Under 24 Hrs. **Funeral** Days Hours 88 Min. 579-18-4088 1 □ M 2 X F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland Prince Georges Directo Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or edical Examiner must be 6916 Elbrook Rd. 20706 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes X☐ No ģ Specify: White ₩ Widowed 4 Divorced Completed ed other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H ant: If Item 27 Is marked oth Lester Stephens Carrie Jennings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6916 Elbrook Rd. Lanham, MD 20706 19a. Informant's Name/Relationship (Type. Print) Patricia Taylor Daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of It
Important: if ite
any injury or of Fort Lincoln Cemetery May 2,2008 1 Burial 2 □ Cremation 3 □ Removal from State Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 8 9013 Annapolis Rd. Lanham, MD. 20706 flications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** un reumonia disease or condition /Medical resulting in death) o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical attending physical for use as the b IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy performe death? 2 No 1∐ Yes 2 No the Hospital or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Surraing Home 5 - Residence 6 - Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending Iniury investigation 1 ☐ Yes 2 ☐ No hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only within 2 and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

CP (5)

DHMH 17 Rev 1/2001

Registra

30. Name and address o

ed (Month, Day,

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

State Registrar 31. Date(fled (Month, Day, Year) APR 3 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Elizabeth Fasika, MD. 575 Main Street, haurel, MD. 20707

MOD 60925

04/24/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 2008 Henry liaM 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number EASTON TALBOT MEMORIAL HOSPITAL AT EASTON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Hours Aug. 11,1920 Maryland 12M 2 F 10d. Inside City Limits 10c. City, Town or Location Hurlock 10g. Citizen of What Country? 10e. Street and Number ZISA 12. Was Decedent Ever in U.S. Armed Forces? 1 Des 2 No 9 4 If Yes, Give Year or Dates: 1949 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 No 1941 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Manufacturine Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Waters HENRY SR. Lelia Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P. S. BOX 144-HUY lock, MD. 21643 Anna 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hurlock, MD S Cometery : 4 ☐ Donation 5 ☐ Other (Specify) veterans 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intermediate Cause (Final Intermediate Cause (21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death INTRA CEREBRAL Immediate Cause (Final disease or condition resulting in death) HEMORRAGE Due to (or as a consequence of) Que to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 Fetal death Month Dav Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ZNo 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

Funeral

Director

death with the Maryland or Items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore,

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

attending physician and for use as the burial-tran

Examiner Be 2 Certification:

Physician/Medical þ Completed

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice within 24 hours a To the Funeral C

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

21601

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ⚠ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident

3 ☐ Suicide 4 ☐ Homicide

31. Date filed (Month, Da

29a. Certifier

5 ☐ Pending investigation 6 ☐ Could not be

1 🔀 Inpatient 28a. Date of Injury (Month, Day Year) Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

28b. Time of

Other: 2 ER/Outpatient 3 DOA 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death Check onl one

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 00059487 29d. Date signed (Month, Day, Year) 5-1-2008

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

John Botsis, M.D., 219 S. Washington St., Easton, MD

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Waters 9:08 PM **Physician** 2008 May Mary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chesapeake Woods Nursing Center

5. Social Security Number 6. Sex 7. Age (Ingl. last birthday, Dorchester Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Feb. 27,1905 Mary land 7. Age (In y s. last birthday) 30X 1 M 2 F **Funeral** 220-01-2909 Usual Residence of Decedent Yrs Director 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Dorchester ambridge Director 10g. Citizen of What Country? 10e. Street and Number Washington 21613 USA Street Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Helper Processingline 18. Mother's Name (First, Middle, Maiden Sumam 17. Father's Name (First, Middle, Last) Be Holland Mattie charles Banks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD.21613 815 Washington St. Cambridge Smith Darlene Waters 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Church Creek, MD. Old Field Cemetery 7/08 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate

Immediate Cause (Final 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 7 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? A Iten, 4 24a. Was an autonsy autopsy performed? deseneratio certificate MACULAR 1 🗌 Yes 2 NO 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 🖼 🗖 o 2 ER/Outpatient 3 DOA 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ this within 24 hours after death.

To the Funerei Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; 1 Natural
2 Accident Injury 5 Pending 2 No 1 Tes investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Lois

31. Days filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NARR

2008 Reg

A.

ORIGINAL

D.O.

rar's Signature

29d. Date signed (Month: Day, Year)

		For				— "			F. 19. on
		State Registrar			Certificate of	Death		eg. No.	108, 1609
Physicia	ın	1. Decedent's Name (First, Middle, Last)		_			2. Date of Deat Month	Day	Year 3. Time of Death
/Medica	ai -	Edwin J.	Zab	el	Ah City Tour	or Location of Death	April 3		08 3:50 a [™]
Examine	er	4a. Facility Name (If not institution, give single Brooke Grove Nurse							
Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birti	hday) If Under 1 Year		8. Date of Birth (Month, Day,		9. Birthplace (State or Foreigr Country)
Director		453 - 18 - 1397	M 2□ F	89	rs. Months Days	Hours Min.			9 Washington, D
>	-	Usual Residence of Decedent		10c. City. Town	or Location				10d. Inside City Limits
shov	<u>_</u>	10a. State 10b. County		,,					1 □ Yes 2 TNo
28a-f	Director		tgomery		Silver Spri	ng	T 4	Oa Citizen of	What Country?
a or	흐	10e. Street and Number 3310 N. Leisure W	orld Blyd	1 #412	2090	6	'	US.	
"natural", or items 23a or 28a-f show edical Expression to use be notified at	Funeral		2. Was Decedent Ev		13. Was Decedent of If Yes, specify Cub		ecify Yes or No-	14. Ra	ace - American Indian,
in the		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ZYes 2 ☐ No				Rican, etc.)		ack, White, etc.
al", o	<u>8</u>	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: u	ınknown	1 ☐ Yes 2 🛣 No	Specify:		Speci	ify: White
natur	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of working	ng	16b. Kind of E	Business/Industry
	ם	Elementary/Secondary (0-12)	College (1-4or 5+)		ed)		.	
ntal Hygiene. Id other than event, the Me	8	17. Father's Name (First, Middle, Last)		wat	chmaker	18. Mother's Name	(First Middle I		vate
& da	Be	John H. Zabel				Eva T.		naraon cama	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
and Mental is marked o aumatic eve	유		ne Print)	10h	Mailing Address (Street	1		r. City or Town	n. State. Zip Code) 20906
Ith ar 27 is trau		19a. Informant's Name/Relationship (Type. Print) Louise Zabel/Wife 19b. Mailing Address (Street and Number or Rural Rot 3310 N. Leisure World B.							
Department of Health and Men Important: If item 27 is marke any Injury or other traumatic once.	-	20a. Method of Disposition			Disposition (Name of y, crematory or other pla				- City or Town, State
nent of int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation / 5 ☐ Other (Specify)	emoval from State	1	y, crematory or other pla of Heaven Co		008	Silve	r Spring,Maryla
ortan ortan Injur	-	21. Signature of Function Service City on e	10	1 -	22. Name and Addr	ess of Facility			
Deparamental Important Irrange once.	- 4	W Welleve	WWO	Men	1	. Collins			Inc. Spri ng Mp 2000 Approximate
	iner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Unorthing Cause (Disease or injury that initiated events	Due to (or as a	consequence of	of):				8 yea
sician and burial-trar	ŭΙ	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a	consequence of	of):		<u>.</u>		
t by the attending physician and tached for use as the burial-tran	edical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ac. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	of pregnancy 2 □ Fetal death time of death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)			N	vate of delivery Month Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1205 AM **Physician** 2006 nthony 4a. Facility Name (If not institution, give street and /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner 5505 Hopkins Bryview Ma Baltimore 5. Social Security Number 6. Sex Baltinore 8. Date of Birth (Month, Day, Year) 10-01-1921 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Days Hours 1**∑**M 2□F Maryland 214-18-7371 86 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 21 No Baltimore Completed by Funeral Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 25 Perry Falls Place 21236 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Xes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 💢 No Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Parts Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Vain Henry Albrecht ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21236 2 Juxon Ct Shelley Albrecht (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Stanislaus Cem. | 05-19-2008 Baltimore, MD St. 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 9705 Belair Rd Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dung Mass cousins disease or condition resulting in death) Due to (o les a consequence of): Securities if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Denier Due to (or as a consequence of): ian/Medicai IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) Physic 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 1 Tyes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

/Medical **Examiner** use as the burial-transit death certificate be executed the attending physician Division of Vital Records, P.O. Box 68760, jo detached à page 2 should be det certificate has been the Hospital or Attending Physician: this After death. hours after death within 24 hours a

To the Funaral D

completely filled i

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked othar than "natural", or itema 23a or 28a-f ehow any injury or othar traumatic evant, if a Modical Examinator must be notified at any injury or othar traumatic evant, if a Modical Examinator must be notified at any injury or othar traumatic evant.

Physician

imore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

30. Name and address

29b. Signature and title of certifies

orc 31. Date filed (Month, Day, Year,

Bayview Circle, Baltimore Md 21224 HOPKINS 32 Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

5505

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** BRUCE ABENDSCHOEN 5:10 A M MAY 10 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMONE JOHNS HOPKING BAYVIRN MEDICAL CENTER 8. Date of Birth (Month, Day Year) 948 Mary Land If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months 1 M 2 □ F 213-52-1654 59 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 USA 1915 Guyway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ñ Yes 2 □ No If Yes, Give Year or Dates: *68-90 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. and Mental Hygiene. is marked other than Elementary/Secondary (0-12) 12 College (1-4or 5+) meat cutter food industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carroll William Abendschoen Artice Marion Croswell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health 1915 Guyway Dundalk, MD 21222 Ellen Abendschoen/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Euneral Sprince L State Anatomy Board 655 W. Baltimore Street Wade, Wirector 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate use (Final disease or co dition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Examiner CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: ed by the attendin 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 1 □ Yes P.0. 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate 1∐ Yes 2 1 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 3□ DOA 1 Yes 2 No 2 ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 1 Natural 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature a title of certifier USTIN RES-000 MAY 10, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Prick BALTIMORK, M.D. 21224 RASTRIN AVRAVE Justin 4940 Registrar's Sigpature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar amend #15 Per FH G879 5/19/08 erfificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MAY 15 2008 ALTERAC 7:45A LAURA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3006 BEVERLY ROAD BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/09/1942 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. 66 219-38-1291 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Eventing to other traumatic events. 1 Nes 2 No Director N/A BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3006 BEVERLY ROAD 21214 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 ☐ Married WHITE Báltimore, Maryland 21215-0036 1 □Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN ALTERAC UNKNOWN HANA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY CONNOR / SOCIAL WORKER 300 METRO PLAZA, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 🛱 Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 05/16/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS. INC. REISTERSTOWN ROAD, PIKESVILLE, MD 8900 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respirar **Physician** onc hove disease or condition resulting in death) /Medical Due to (or as a nsequence of): **Examiner** Collapse if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner law requires that the death certificate be executed physician and s the burial-trans lohacco Due to (or as a consequence of) as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor Month Year 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has hirector, page 2 s autopsy performed?

1 Yes 2 No 2 🗆 No Division of Vital 1 □ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this of funeral dire 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

SHAWN 31. Date filed (Month, Day, Year)

MC 2. Registrar's Signature Car Ward

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3333 N. CALVERT ST.

P.0.

0058860

MAY 15, 2008

21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 13, 2008 **Physician** 8:30P M Patricia Lee Ashby /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 9009 Groffs Mill Drive Owings Mills If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, December 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Months 1 □ M 14,1934 California 559-44-2608 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County 1 ☐ Yes **XXX** No Directo Maryland Baltimore Owings Mills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21117 USA 9009 Groffs Mill Drive Funeral 12. Was Decedent Ever in U.S. Armed Forsec? 1 ☐ Yes 270 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Tes XX No White Specify: ģ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Balto Co Board of Education Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Courtney Graydon Bannert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DTR 620 Anneslie Road Baltimore, Maryland 21212 Julie Ashby Kromkowski 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 20c. Location - City or Town, State GreenMount Crematory May 19,2008 Baltimore, Maryland □Donation 5 □ Øther (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Forms Inc ignature of Fu 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CANDIOUNSCOLO Atheros clentic Due to (or as a consequence of) Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2□ No 1 ☐ Yes 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → ဥ 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be

Director: After the

within 24 hours a To the Funeral I

Medical

State

Registrar

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

30. Name and addre

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

g/

determined

9 2008

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1)27127

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

s of person who completed cause of death (Item 23a) (Type, Print)

ile. Stem to

3€. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 6:44 a May 8, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1207 Lakeside Drive Date of Birth (Month, Day, Year) Apr 19, 1930 Birthplace (State or Foreign Country)
 Maryland If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In vrs. last birthday) 6 Sex Months Davs Hours Min 1 M 2 □ F 78 216-24-7700 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 ☐ No Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21218 1207 Lakeside Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2 🛣 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Self Employed Elementary/Secondary (0-12) College (1-4or 5+) Rarber 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carrie Adams Layfield Adams Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 1207 Lakeside Drive Baltimore, Maryland 21218 Catherine Adams 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland 05/14/08 Arbutus Memorial Park 4 Donation 5 Other (Specify) 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 ervice 21. Signat M of Fune al Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) failure neart Due to (or as a consequence of) cardiumyopas Due to (or as a consequent of) Due to (or as a consequence of):

Physician /Medical **Examiner**

> the as attending p for use as

> ed by the a

signed t

cate has been sig , page 2 should b

certificate

this

After t

death.

24 hours after deatl • Funeral Director:

within 2. the

funeral director.

filled in by

completely

Physician:

Hospital or Attending

Department of Health as Important; if item 27 is any injury or other trau

Pages 1

The law requires that the death certificate be execute

Division or Vital Records, P.O. Box 68760

Physician /Medical

Examiner

Director

Funeral

9

Completed

Be

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Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

within 72 hours after death

1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than

Saltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-tra physician

Physician/Medical

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Completed

Be

Certification: To

Medical

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Was decedent pregnant

4□Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

Day

23e. Did tobacco use contribute to the cause of death? 4 Whknown 3 Probably 1 ☐ Yes 2 ☐ No 24a. Was an

autopsy performed? 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 Pending investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 ☐ Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of sertifier

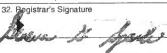
6 ☐ Could not be

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.S. Rajapakse, 25 Main St. Suife

State Registrar



ORIGINAL

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEN TITEM 20 per FH 0879 5/19/08 WS
State of Maryland / Department of Health and Mental Hygiene 1- State amend #18 Per FH G879 5/21/08 Hificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** BLAKNEN MA GIORIA 15 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Regis ROAL Boltimore 6006 St. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12/28/1959 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 🗶 F Months 48 Director 229-90-2843 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County "natural", or items 23a or 28a-f show edio I Exa<u>miner must be notified at</u> 1X Yes 2 □ No Directo Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 U.S.A. 6006 St. Regis Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Fast Food Supervisor permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, is 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Hattie Haddie Mae Washington Be ၉ Robert Lee Perkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6006 St. Regis Road, Baltimore, Maryland 21206 19a. Informant's Name/Relationship (Type. Print) Joshua Blakney / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Termation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 05/17/2008 Baltimore, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1 monediate **Physician** MYOCHOURAL disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner 0100014 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trai The law requires that the death certificate be execu Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4⊡Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 1 Inpatient Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier hrook mo SU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3120 Erdna. . Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year 10:43 P Bainbridge Wallace Butler, 2008 May 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel Regional Hospital Prince George's Laure 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Months 1**X** M 2□ F Hours 67 July 1940 Director 579-54-8325 1, Washington, D.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 1s marked other than "natures" ---- any Injury or other trainment. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Prince George's Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14809 Bowie Road, Apt. 102 Completed by Funeral 20708 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Geico Insurance Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bainbridge W. Butler, Sr. ဥ Emily J. Farrar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Margaret Butler/Wife 14809 Bowie Road, Apt. 102, Laurel, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 5/17/2008 Odenton, MD 22. Name and Address of Facility Donaldson Funeral HOme, P.A. 21. Signature of Funeral Service Licensee M01103 313 Talbott Avenue, Laurel, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final **Physician** Cardiac Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Heart Attack Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ospital or Attending Physician: The law requires that the death certificate be executed hours after death.

uneral Director: After this certificate has been signed by the attending physician and the burial-transit Diabetes Mellitus Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Hypertension IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ڄ Dyslipidaemia 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes XXNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2XXER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide ģ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 61533 May 14, 2008

State Registrar

Division of Vital Records,

COALL

Meade Road, Suite 100, Laurel, MD

3450 Ft.

32. Registrar's Signature

DEAGNS.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gulshan Nazir

31. Date filed (Month, Day, Year)

		1 - For State Registrar	State of M	laryland / Dep		lealth and N	lental Hyg	•	08	1610
Physici /Medi		1. Decedent's Name (First, M Sharon	fiddle, Last) Faye		Beazley		2. Date of Deat Month May 15	Day 2008	Year	3. Time of Death 9:30 pM
Examir Funeral		4a. Facility Name (If not instituted as Stella Mari 5. Social Security Number 216-54-2811		r) .ge (In yrs. last birthday, 57 Yrs.	Towson	Cocation of Death If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 26		9. Birthpla	e ace (State or Foreign ry) inia
death with the Maryland or 23a or 28a-f show continued to continue at the continue	irector	Usual Residence of Deceder 10a. State 10b. Co		10c. City, Town or L	ocation chville			Og. Citizen of V	10	od. Inside City Limits 1 □ Yes 2 □ XNo
E it e	d by Funeral Director	331 Glenville 11. Marital Status 1 Never Married 2 🛣 3 Widowed 4 Divo	Married 12. Was Deceden Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	X vo :	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 ☒No	ispanic Origin? (Sp an, Mexican, Puerto Specify:		Specify		te. te
within jene.	Completed	(Specify only has been selementary/Secondary (0-12 years		(Give life.	edent's Usual Occup of kind of work done of DO NOT use retired of Employe	during most of work f) :d	ing	Commer	cial	ustry
faryland 2 2 should be filed v and Mental Hygis is marked other aumatic event, it	To Be	17. Father's Name (First, Mic Robert Frank 19a. Informant's Name/Rela	Warner	19h Mail	ing Address (Street		acquelin	e Baird		Cade)
Te, 1 and 1 Hear term?		Charles Beazl 20a. Method of Disposition		nd 331	Glenville osition (Name of matory or other place	Road, Ch	nurchvil	le, Mar 20c. Location -	yland City or Tov	21028 wn, State
Baltimore, permit. Pages 1 ar Department of Hec Important: If Item any Injury or othe		4 □ Donation 5 □ Other 21. Signature of Funeral Ser	er (Specify)	Bayview	Crematory 2. Name and Addre Onnelly F 110 Solle			Baltimo: undalk, undalk,		
Box 68760, A seath certificate be executed attending physician and for use as the burial-transit	dical Examiner	23a. Part 1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b	line.	ter the mode of dyin	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
the d	Physician/Med	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □Yes 2 ☒No 9 □ Unknown	1 ∐ Live birth	2 Fetal death 3 at time of death 5	☐ Ectopic pregnanc	у		23d. Dat Mo	e of deliver	ry Day Year
Vital Records, P.O. slclan: The law requires that the de certificate has been signed by the rector, page 2 should be detached to	Completed by Pi	Part II. Other significant cor	iditions contributing to death	but not resulting in the u	underlying cause give	en in Part I.		n 24b. No n 24b. No ned?	3 ☐ Proba	e cause of death? ably 4X Unknown by findings available pletion of cause of
n of ng Phy: fter this	Be	25. Was case referred to me examiner? 1 Yes 2 XNo 27. Manner of Death 1 Natural 5 Pe 2 Accident in	Hospital: 1 ☐ Inpa		of 28c. Injur Work	y at	h (Check only on	e) ence 6 X Oth	er (Specify	HOSPICE
Divisio To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide de	ould not be 28e. Place of Ir	njury - At home, farm, st etc. (Specify)			28f. Location (St. City or Town		er or Rural	Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	Medical		tifying Physician: To the besical Examiner: On the basis and manner:	of examination and/or i		pinion, death occur	rred at the time, d		and due to	the cause(s)
1		1 An	rson who completed cause of E WRIGHT 2300	DULANEY V	Print) S	2740	M, MD 21	May	16	m 2008
Sta Registr		31. Date filed (Month, Day,)		trar's Signature	parti					

08-03655 Lola

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

03655		Please Type or	f Maryland / Depart	ment of	Health and	Mental H	ygiene	/ \	000 1717		
a Biernack		State of	Certi	ficate of	Death		Re	g. No	008 1610		
Physician	Re / 1.	distrar Decedent's Name (First, Middle,Last) Lola Belle Bie					2. Date of Death Month May 13, 20	Day Year	3. Time of Death 1040 hrs		
ા Examine		. Facility Name (if not institution, give s		4	b. City, Town, or L Baltimore	ocation of Death	1	4c. County of De			
Funeral		St. Agnes Hospital Social Security Number 218–28–1321 6. Sex		st birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Mir	 - / /4		Birthplace (State or preign Country) W.Va.		
Director	Ü	sual Residence of Decedent	M 2 V F	Town or Locati					10d. Inside City Limits		
nd show any ce.	١,	Maryland Baltimon		tonsvi	lle			0g. Citizen of What	1 Yes 2 No		
th the Maryland 23a or 28a-f show notified at once.	Director	De. Street and Number 6005 Burnt Oak I	Road		10f. Zip Code 21228			United St	tates American Indian, Black,		
215-0036 be flied within 72 hours after death with the Maryland mtal Hygiene. rked other than "natural", or items 23a or 28a-f she cent, the Medical Examiner must be notified at once	uneral	1. Marital Status Never Married 2 Married	12. Was Decedent Ever in U.s Armed Forces? 1 Yes 2 No	If Y	es Decedent of His ves, specify Cuban ves 2 No	i, Mexican, Puer	Specify Yes or No to Rican, etc.)	White, e			
ours after a	ed by	15. Decedent's Education (Specify on	If Yes, Give Year or Dates: hy highest grade completed)	16a. Deceder during n	nt's Usual Occupa nost of working life	tion (Give kind o	of work done etired)	16b. Kind of Busin	ness/Industry Home		
1215-0036 Id be filed within 72 hours a fental Hygiene. narked other than "natura event, the Medical Examin	ompleted	Elementary/Secondary (0-12)		Н	omemaker T	18.Mother's Na	me (First, Middle,	Maiden Surname)	nome		
e, MD 21215-0036 and 2 should be filed within 7 Health and Mental Hygiene. item 27 is marked other than r traumatic event, the Medica	Sec.	7. Father's Name (First, Middle, Last) Richard Clay	Williams	19h Mailir	ng Address (Stre	Ju	anita Ru	th Goff umber, City or Town,	, State, Zip Code)		
- p 2 2 5 1	٩	19a. Informant's Name/Relationship (T Mark Biernack / S	Son	11 8	Somerset	Road C	atonsvil	le, MD 4	21228 City or Town, State		
nore, MD 2 ages I and 2 shoul nt of Health and M rt: If item 27 is m other traumatic		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	crematory or o	other place) edral Cen	ı. 5/	17/2008	. 4	ore, Maryland		
Baltimore, permit. Pages la Department of He Important: If its injury or other t		4 Donation 5 Other Specify 21. Signature of Funeral Service Licer	nsee	22.	Name and Address Hubbard 4107 Wil	ss of Facility Funeral kens Av	Home, 1 enue Ba	inc. altimore,	MD 21228		
Physician Vedical	23a. Part I. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory discrete.										
aminer		miniculate casculting in death)	Due to (or as a consequence Deforation of left iliac	of): vein during	g catheterizati	on procedur	e				
	iner	sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause									
uted d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence d.								
0, e be executed ysician and burial - transi	ledical	UNPENDED IF FEMALE:	AMENDED 23c. If yes, outcome of pre	egnancy				23d. Date of Month	f delivery Day Year		
iox 68760, cath certificate be executed e attending physician and for use as the burial - transit	sician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of	2	Fetal death Other (Specify)	3 Ectopic pr	regnancy	Month	Duy		
that the death	عَ ا	1 Yes 2 No 9 Unknow Part II. Other significant condition	s contributing to death but no	ot resulting in t	he underlying caus	se given in Part			ribute to the cause of death? Probably 4 Unknown		
S, P.C quires that on signed ald be deta	ted by	Cirrhosis of liver, athero	osclerotic cardiovascula	r disease,	diabetes mell	itus	24a. V		Were autopsy findings available prior to completion of cause of		
ecord he law ree te has be	Completed						1 V	performed? Yes 2 No	death? 1 Yes 2 No		
/ital Rec ysician: The L his certificate b	S S	25. Was case referred to medical				lace of Death (C	Nursing Home 5	Residence 6	Other:		
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by funeral director, nase 2 should be detach.	T .	examiner? 1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) May 13, 2008		e of Injury 28c.	Injury at Work?	28d. Desc	ribe how injury occu ion of vein duri	rred		
ision 'Attendir er death.	Cortification:	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could I	gation 28e. Place of Injury -				006 1 000	tion (Street and Num own, State) aton Avenue, Bali	nber or Rural Route Number, Cit timore, MD		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici To the Funeral Director: After this certificate has been signed by the attending physici	in medi				occurred at the tim	ne, date and place	I don to the		per as stated.		
To the I	completely	(check only one) 2 Medical Examo 29b. Signature and title of certifier	iner:On the basis of examination and manner stated.	icense number		29d. Date si	gned (Month, Day, Year)				
		Lasha J	elfus	(Item 23a)).C.M.E.		May 14,	ZUU0 		
5		30. Name and address of person v Tasha Greenberg MD.	Assistant Medical Ex	xaminer	111 Penn Str	eet, Baltimo	re, MD 21201	1			
Rec	Sta	14144 1 4 41	2008 32. Registrar's Signature	J. J	pode						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 14, May Physician 2008 CHARLES FREDERICK BRANDT Sr. 2:15 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Brightwood Gardens Baltimore Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1□M 2□F Months Days Hours 218-01-3472 90 15,1917 Maryland Aug. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □ Yes 2√XNo Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6451 N. Charles St. 21212 U.S.A. by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: White 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Self-Employed Architect 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Conrad Brandt Elsie Vogel ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mairi Patricia Maguire Niece 730 E.Lake Ave. Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory 5-16-08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licenses 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 12NS DROCHATE Die to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No perform 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 A Other (Specify) ASSISTED LIVING 1 ☐ Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

the burial-tran attending physician for use as the buria been signed by i should be detach page 2 s certificate this

Division or Vital Records, P.O. Box 68760.

or Attending Physician:

funeral After within 24 hours after death.

To the Funeral Director: /

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Type, Print) N Charles ST PONSIN MOZIZOY

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDN S (CAPALUES), WY 6701 N CM

29c. License number

29d. Date signed (Month, Day, Year)

MM 15 2007

10 State Registrar

within 24 hours a To the Funeral I

Medical

31. Date filed (Month, Day, Year)

2 Accident

3 ☐ Suicide

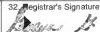
29a. Certifier

4 Homicide

2003

6 ☐ Could not be

determined



Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Registrar

within 24 hours a

Medical

29a. Certifier

(Check only one)

29b. Signature and

EDDIE NAKHUDA,

MAY 1 9 2008

31. Date filed (Month, Day, Year)

MAY

BIDDISON,

2300 DULANEY VALLEY ROAD

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

MD

TIMONIUM

21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 17, Year Physician 2008 10:40 A M Marv Jean Bove /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilcrest Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 4/23/1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours Months 1 □ M 2 🔀 F Marvland 215-14-6263 84 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Me it all Examiner must be notified at MD 1 ☐ Yes 2 No Perry Hall Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9313 Kilbride Court 21128 **USA** Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. be filed within 72 hours after intal Hygiene.

dother than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify. Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Homer Wise Urith Taylor ္ရ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Bove, II / Son 9313 Kilbride Court Perry Hall, MD 21128 Important: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. Date 20c. Location - City or Town, State 20a. Method of Disposition 5 1 □xBurial 2 □ Cremation 3 □ Removal from State 5/21/2008 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) any Injury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, ENDSTAGE Immediate Cause (Final **Physician** ecos disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury Dusito (or se e nonsequation of) Examiner the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 XNo 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be Yes 2□ No 3□ Probably 4□Unknown Completed UNG 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perfor the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide

The law requires that the death certificate be executed signed by has After this certificate To the Hospital or Attending Physician: hours after death.

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Division or Vital Records,

Pages 1 and 2 should

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within 24 hours a To the Funeral L

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Towsentown 32. Registrar's Signature

State Registrar

Medical

29a Certifier

(Check only

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** MAY 12:51 AM Craig 12 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GOOD SAMARITAN BALTIMORE BALTIMORE CIT HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year 1□M 2X F 225-14-9167 88 Director July 27, 1919 Virginia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Marvland Baltimore Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 8300 Kendale Road 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural" or fler 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Completed by Specify. 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hairdresser Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be flealth and Mental I Stephen M. Turner Flora Turner Craig 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Verona Hall (Niece) 1016 Country Club Dr., Martinsville, VA 24112 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 5/16/08 Mt. Hermon Ch. Cem. 4 ☐ Donation 5 ☐ Other (Specify) Bassett, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bassett Funeral Service علا ud 3665 Fairystone Park Hwy., Bassett, VA 24055 234. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ATHEROSCLE ROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 PERIPHERAL VASCULAR DISEASE 1 ☐ Yes 2 ☐ No 3X Probably 4 □Unknown Completed CONGESTIVE HEART 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform HYPERTENSION 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1XNatural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. RES 05/12 2008 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h

Registrar

DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

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2008

5601 LOCHRAVEN BIND BALTIMORE

32. Registrar's Signature

MD

			For State	State of Mar	•			Mental Hyg	giene	000	10111
			Registrar		Ce	rtificate of	Death		Reg. No.	UUO	10111
	Physici	20	Decedent's Name (First, Middle, Last	it)				2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		Beulah E11	en Chipl	is			May	17,		8:45am M
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death)	4c. C	ounty of Death	
			Carroll Hospic	e Dove Ho	use	West	ninster			Carrol	1
	Funeral		5. Social Security Number 6. S		In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h v. Year)	9. Birthp	lace (State or Foreign
	Director		173-09-0119	^{□ M 2} M F 93	Yrs.	Monard Bayo	110010	Apr 24			PÅ
	ъ.		Usual Residence of Decedent 10a. State 10b. County	1.	0c. City, Town or L	a action					Od Inside City Nivete
	aryla shov dat	_			oc. City, Town of E	ocation					0d. Inside City Limits
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	th w	<u>a</u>	250 Saint Luke	Circle		2:	1158			USA	
	eems er m	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	- 14	 Race - Americ Black, White, 	
9	after or It		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐XNo If Yes, Give		1 □ Yes 2 □ No	Specify:				
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21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ant, the Medical Examinar must be notitled at	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Giv	edent's Usual Occup e kind of work done	during most of wor	rkina	16b. Kind	d of Business/In	dustry
7	ithin nan " Me	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		_		
	ygier ygier er th	ပ်				<u>Homemak</u>				omesti	. C
пd	tal H	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden S	lurname)	
/la	Ment ker	ျှ	William Hen	ry Setzer			Cor	a Dief	fenb	ach	
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "raumatic event, the Mec		19a. Informant's Name/Relationship (ing Address (Street	and Number or Ru	ıral Route Numbe	ər, City or	Town, State, Zip	Code)
	1 and 2 Health Tem 27		Gail C. Meehan	(Daughte	r) 620	4 Honeyo	comb Ct.	, Elde	rsbu	rg, MI	21784
<u>S</u>	ges 1 and 2 should be filed within 72 hours after death with the Marylar It of Health and Mental Hygiene. If item 27 is marked other than "naturat", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition		20b. Place of Disp		i	Date		ation - City or To	
Ĕ	Pages nent of l int: If ite		1 M Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)	Fairvie	w Cemete	ery 5/2	20/08	Dush	ore, P	Α
altimore,	permit. Pages 1 a Department of He Important: If item any Injury or othe		21. Signature of Funeral Service Licer			HAIGHT FU					
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5	A 4 20		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused th							Approximate Interval Between
	Physician		Immediate Cause (Final	ST -	and in	1. Hr	tome	/)	110	all	Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a c	consequence of):	47110	The said	100	all	ix	yu-
	Examiner										
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Box	sath atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at tir	Fetal death 3	☐Ectopic pregnand☐ Other (specify) _	У		23	Bd. Date of deliv Month	ery Day Year
-	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown	ne or death 5	Other (specify) _					
P.O.	The law requires that the death certific ate has been signed by the attending proage 2 should be detached for use as	F.	Part II. Other significant conditions of	contributing to death bot	oot resulting in the	underving cause di	ven in Part I	23e. Did t	ohacca us	e contribute to t	he cause of death?
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<u> </u>		ПO						perfo	2 No	death? 1 ☐ Yes	No
or Vital Records,	i lcian: Th certificate rector, pag	Be	25. Was case referred to medical				26. Place of Dea	ath (Check only d			
r <	Physician: this certific	To E	examiner? 1 ☐ Yes No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	ent 3□DOA Ot	her: 4 Nursing H	lome 5 ☐ Resi	dence 6	Other (Speci	Abarrice
0	aling Ph n. After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day)	28b. Time (ear) Injury		iry at	28d. Describe	how injury	-	0
Ö	Attending r death. ector: After by the funer	atio	1 Natural 5 ☐ Pending investigation		- injury		Yes 2□No				-
Division	Atte	ij	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined			treet, factory, office		28f. Location (a City or Tox	Street and	Number or Rur	al Route Number,
Ö	al or A s after al Dire	Certification:		ballang, etc.	opcony)			City of For	in, state)		
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	T 4 T 9	1≚	one) Z Wedical Exa	miner: On the basis of e	Aarminauvii aliu/or	mvesugadon, in my	opinion, death occ	uned at the time,	uale and	piace, allu uue i	o trie cause(s)

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To the complet

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:30 A^M Vincent T. Conroy, Jr. May 17 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** St. Elizabeth Nursing & Rehab Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F Months Hours 85 July 1922 Maryland Director 30, 218-18-1623 Usual Residence of Decedent with the Maryland r than "natural", or Items 23a or 28a-f show the Medical Experient must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Director Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 215 Brookside Drive Completed by Funeral 21228 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Yes 2 No If Yes, Give Year or Dates: 1942-45 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than Banker Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental 1-27 is marked ot traumatic ever 2 should be မှ Vincent T. Conroy, Sr. Sarah Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is Mary Edna Conroy Wife 215 Brookside Drive; Catonsville, MD 21228 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 5-21-2008 | Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses 1630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** END HAY Alzheimer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 I No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy certificate 2 2 No 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) After 1 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 A Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital c within 24 hours af To the Funeral Di 29a. Certifier l 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

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Baltimore,

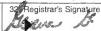
Box 68760,

P.O. |

Division of Vital Records,

State Registrar 31. Date filed (Month, Day, Year) MAY 1 9 2008

29b. Signature and title of certifie



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDMULT P. DECEMBE 405 Reland Relanguage And Million Common

29d. Date signed (Month, Day, Year

DHMH 17 Rev 1/2001

Registrar

MAY 1 9 2008

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Gloria Miles Cherry 14 7:15 AM 2008 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Lorien Care Center - Mays Chapel Timonium Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 X F Months 86 Director 058-18-6187 November 20,1921 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at Maryland Baltimore Lutherville 1 ☐ Yes 2X No Funeral Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 220 Felton Rd. 21093 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or iteπ edical Examiner 1 and 2 should be filed within 72 hours after the theath and Mental Hygiene.

em 27 is marked other than "natural", or itel the traumatic event, the Medical Examiner. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify: Completed by 3. Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Director of Education Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Lewis Miles Catherine O'Connor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darnestown, MD 20878-3915 Cathleen Cherry/daughter 14404 Falling Leaf Dr. t; If item 27 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of important; if any injury or 4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem GardMay 19,2008 | Timonium, Maryland 21. Signature of Funeral Service Licenses J²² Name and Address of Facility John O. Mitchell IV, Funeral Services of Dulaney Valley, P.A. 200 E. Padonia Rd. Timonium,MD 21093 Valley, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Du to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mor 1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy for Month 4☐Pregnant at time of death 5 Other (specify) ed by the a Ö ۵. signed by the period of the pe significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No performed Yes 2 Vital 1∐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA o this funeral 27. Manner of Death 1 DNatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division Hospital or Attending 5 Pending investigation Iniury 1 □ Yes 2 □ No ours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 30. Name and address of person who completed cays 6701 475MC 31. Date filed (Month, Day, Year) \$2. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

MAY 19

2008

08-03613	
Walter Crowner	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day May 11, 2008 1609 hrs Medical Examiner Walter Crowner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Hours Months Days Country) Director 1X XM 2 F /12/1964 N.T 44 213-88-0956 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 X XYes 2 No Catonsville or items 23a or 28a-f shomust be notified at once. Baltimore Md. 10g. Citizen of What Country? 10f. Zip Code Directo 10e. Street and Numbe USA 21228 1075 Southridge Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 X Married Yes Specify: Black If Yes, Give Year Yes 2 No specify: 3 Widowed 4 Divorced ۾ 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done Pages 1 and 2 should be filed within 72 hours inent of Health and Mental Hygiene. ant: If item 27 is marked other than "naturs or other traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Private Company Welder 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emma Ruth Pearl Be Walter V. Burroughs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 1075 Southridge Road, Catonsville, Md. 21228 Diana Crowner 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Important: If its injury or other to Removal from State 1 X Burial 2 Cremation 5/19/2008 Windsor Mill, Md. King Memorial Pk Donation 5 Other Specify ^{22, Name and Address of Facility}
Estep Brothers Funeral Service, PA
1300 Eutaw Place, Baltimore, Md. 21217 21. Signature of Funer V Servi, e Licen, ee Approximate Interval 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Alcohol and narcotic intexication Immediate Cause (Final disease `⊏xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. Physician/Medical X UNPENDED physician a 25a, FII, 27, 28a-f, per ME, g880 6/5/08 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown ₽ Cocaine use Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No this certificate 26 Place of Death (Check only one) 25. Was case referred to medical Be Other; examiner? Nursing Home 5 Residence 6 DOA Inpatient 2 🗸 ER/Outpatient 3 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? To the Funeral Director: After t completely filled in by the funeral 28b. Time of Injury 27. Manner of Death Certification: Natural 1 Yes 2 y No 5 Pending Fnd 5/11/2008 Fnd 5:30 pm unk Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 1700 N. Castle St. Baltimore. MD 6 X Could not be Suicide Found: residence (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 12, 2008 O.C.M.E 30. Name and address of person who completed cause of leath (Item 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registra

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $\angle \cup \cup \Diamond$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 150 am 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Maryland N/A apperal ge (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2□₹ Davs Hours Director 224-34-4026 Virginia 79 Nov 15, 1928 Usual Residence of Decedent with the Maryland 10h. County 10c. City, Town or Location 10d. Inside City Limits show 1 □ 1 × 2 □ No Examiner must be notifled Director Baltimore N/A Maryland 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 446 Oxford Court 21201 U.S.A or items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Nxx β Specify Black 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Ferrell Abram Winbush 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 446 Oxford Court Baltimore, Maryland 21201 Cherell Conway 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Commation 3 ☐ Removal from State 05/16/08 Catonsville, Maryland 5 ☐ Other (Specify) 4 ☐ Donation Metro Crematory, Inc. 21. Signature of Funeral Service Lig 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part T. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 4 Unknown 1 Yes 2 No 3 Probably Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy perform Division or Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After Certification: (Month, Day 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

2008

ne

Mil

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 16, 2008 12:40 A M Beatrice A. Chudzik 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Touson Gilcrest Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Hours Min. 11/26/1922 Louisiana 1 □ M 2X F 137-16-2261 85 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Parkville MD Baltimore 1 ☐ Yes 2XXNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 1907 Rushlev Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify. Specify: White 3XXVidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Singer/Dancer Entertainment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ada Barry Paul Valachovic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 320 Nagog Hill Road Acton, MA 01720 Michael O'Connell/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5/19/2008 Baltimore, Maryland Moreland Mem. Park 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Funeral Service Licens Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mentles AVIM disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) クレと Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28b. Time of

Examiner certificate be executed and burial-trai Box 68760, attending physician nse for P.0. the detached signed by to Division or Vital Records, page 2 s certificate has

funeral After To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After the completely filled in by

Physician

/Medical

Examiner

Funeral

Director

than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at

the

permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygin important: If item 27 is marked other any Injury or other traumatic event, the

Physician

/Medical

Examiner

Director

Funeral

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Completed

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

20 State

Physician/Medical Completed Be ပ Certification:

2 Accident 6 ☐ Could not be determined 4 ☐ Homicide

5 Pending investigation

28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N. Charles St. Balto. Md 2120x

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

nyo

29c. License number 25205

29d. Date signed (Month, Day, Year) MAY16, 2008

31. Date filed (Month, Day,

1 Natural

3 ☐ Suicide

29a. Certifier

32. Registrar's Signature

30. Name and address of person who completed cause of ath (Item 23a) (Type, Print)

Registrar

Medical

Binc

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 2008 Willie C. Dawkins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore University Speciality Hospital B. Date of Birth (Month, Day, Year) 933 S. Carolina If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Age (In yrs. last birthday) **Funeral** 1**√** M 2□ F 249-40-7764 Director Usual Residence of Decedent Maryland -- , r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be USA 21216 2926 Westwood Avenue 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Petty Truck Company Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 9 nent of Health and Mental | int: if item 27 is marked o Unknown Annie Lois Dawkins Ith and Menta 27 is marked r traumatic e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State 7/1 Coda)d 3328 Sumter Avenue Baltimore, Maryland 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
important; if item 27 is
any injury or other trau Sybil Hill/ Daughter 21215 20b. Place of Disposition (Name of cemetery, crematory or other p Cemetery 5/17708 20c. Location - City or Town, State Catonsville, Maryland 20a. Method of Disposition 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Md 21215 21. Signature of Functial Service Licenses 23a. Part1. Pinter the screen, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart billure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sease or condition resulting in death) **Physician** TWO WEEK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Linknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ IRA TORY 1 Yes 2 No 3 Probably 4 Ninknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy
performed?
Yes 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Wither (Specify) 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural (Month, Day Year) 5 Pending To the Hospital or Attendii within 24 hours after death.
To the Funeral Director: Ar completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061765 MAY BH 2008 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BENFIT QUAINOU WWO 3350 WILKENS AVE #307 BALTIMONE MO 21225 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 9 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ZOO 8 Physician 3:10A M 4a. Facility Name (If not institution, give street and number) 14 DICKENS YA-/Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. ace (State or Foreign (In vrs. last birthday **Funeral** Months Days Hours Min 10 M 2 □ F Yrs. Director nce of Decedent 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Director BURG 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be it 2 should be filed within 72 hours after death v n and Mental Hygiene. 'Is marked other than "natural", or Items 23a Funeral Was Decedent Ever in U.S. Armed Forces? 1 Dres 2 □ No If Yes, Give Year or Dates: A D Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 3 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 Is any Injury or other trauonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State of Disposition 1 Deurial 2 Cremation 3 Removal from State ENW. FUDSO 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 2829 22. Name and Address of Facili BALTO Thomas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DENENTIA /Medical Due to (or as a consequence of) Examiner ASPIRATION Sequentially list conditions sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit Chronic Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No thours at er death.

uneral Director; A
ely filled i by the fi 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 | Homicide within 24 hours a To the Funeral E Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Spepti MD 15 00053150

9650 Senhajo Road

ORIGINAL

suite 110 Columbia

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sup Le 9 (32. Registrar's Signature

Shokun male

31. Date filed (Month, Day, Year)

08-03557 Ту

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

yrone Darden	State of Maryland / Department of Health and Menta 1-For State Certificate of Death		2008 1012
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	Reg. No. 2. Date of Death	3. Time of Death
Medical Examiner	Tyrone Darden	Month Day May 9, 2008	Year 2000 hrs
M.	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of December 2626 Asquith Street Baltimore	Death 4c. Co	unty of Death
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2		YYYY) 9. Birthplace (State or Foreign
Director	217-68-4090 1X M 2 F 49 Yrs. Months Days Hours	Min. 6-8-1958	Country) MD
	Usual Residence of Decedent		
any	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
faryland 28a-f show any Lat once. ector	MD N/A Baltimore		1XXYes 2 No
he Maryland or 28a-f sh iffed at once	10e. Street and Number 10f. Zip Code	10g. Citizen	of What Country?
3a or otified	2626 Aisquith Street 21218	US	
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P		Race - American Indian, Black, White, etc.
집 호텔 교	1 X Yes 2 No	Sne	ecify: Black
by miner by	or Dates: 163 Decedent's Liquid Occupation (Give kin	and the second s	of Business/Industry
2 hour "nate	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT us	e retired)	nivergity of Md
5-0036 ed within 72 hour stygiene. other than "natu he Medical Exau	12th grade College Supervisor of Ma	intenance U	niversity of Md
21215-0036 Mental Hygiene. marked other than "natural", e event, the Medical Examiner To Be Completed by	17. Father's Name (First, Middle, Last)	Name (First, Middle, Maiden Sur	name)
De fi		n Darden	
D 21 should and Me is ma atic ev	19a. Informant's Name/Relationship (Type, Print) Jean Darden-Mother 19b. Mailing Address (Street and Number 1906 Northbourn		
MD and 2 she salth and 2 seem 27 is raumati	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		cation - City or Town, State
Baltimore, MD 2 bernit. Pages I and 2 shou Department of Health and Important: If item 27 is r injury or other traumatic	1 V Surial 2 Cremation 3 Removal from State crematory or other place)	16 2000 000	naa Milla MD
t. Pag tment tment rtant:	4 Donation 5 Other Specify.		ngs Mills, MD
Baltimo permit. Page Department or Important: injury or oth		March F/H E th <u>Avenue Ba</u>	ast lto, MD 21202
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car	diac or respiratory arrest, shock,	, or heart Approximate Interval Between Onset and
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Cirrhosis Of Liver		Death
⁻ xaminer	or condition resulting in death) Due to (or as a consequence of):		
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
in i	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		
ecuted and transit	events resulting in death) Last Due to (or as a consequence of): d.		
be executed isisian and urial - trans	UNPENDED AMENDED # 23a & 27 per MFD G-880 6/16/08 reb 23c If yes pulsome of prepagory		
	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 3 Federal death 3 Federal Control of the state of t		Date of delivery Year
ox 68760 ath certificate battending physicar use as the busician/Me	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other (Specify)	oregnancy Mi	ontil Day Teal
	1 Yes 2 No 9 Unknown		
O. BC at the dead by the stacked for Physical Physical Control Physical Control Physical Physical Control Physical Physi			e contribute to the cause of death?
by P.C.			No 3 Probably 4 Unknown
ords		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
Records, The law requires, fricate has been sig., page 2 should be		performed? 1 ✓ Yes 2 No	1 Yes 2 No
cian: Certific	25. Was case referred to medical 26. Flace of Death (
Physic Physic ral dire	1 V Yes 2 No Inspiral 1 Inpatient 2 ER/Outpatient 3 DOA		ce 6 Other: Scene
ding I		1	occurred
Sion Attender death death death by the	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc		Number or Rural Route Number, City
Division of Vital Records, P.O. spital or Attending Physician: The law requires that th rours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach. Certification: To Re Completed by P.	3 Suicide 6 Could not be determined (Specify)	or Town, State)	,
D Fill By		ce, and due to the cause(s) and	manner as stated.
To the Ho within 24 To the Fu completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.		
			ate signed (Month, Day, Year)
	Maybre Bre Krell O.C.M.E.	Ividy	10, 2008
Ø	30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore.	MD 21201	
Stat			
Registra			
DHMH 17 Rev 1/2001	ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Constance Dolle 2008 4:15 16, May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 5523 Willys Avenue Arbutus Baltimore 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/20/1923 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 1 ☐ M 2 🗓 84 215-18-5625 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☑ No Director Baltimore Arbutus MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21227 USA 5523 Willys Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Ó Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Paul Clements Edna B. Dunnock 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Dolle / Daughter 5523 Willys Ave., Arbutus, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department or Important: If any Injury or once, Loudon Park Ceme. 5/20/2008 Baltimore, MD. 21. agnitury of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) fuse **Physician** cell 4 Cars /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗀 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After completely filled in by the funera Certification: 5 Pending investigation (Month, Day Year) 1 Anatural Injury 1 ∏Yes 2 ∏No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed Month! Day, State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ekman

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29c. License number

022782

2 401 West Beloeke Avenue, Baltinove, Maryland 2121)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () [] 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yeer **Physician** 3:20 AM mal 2008 Virginia Dixon /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner mal Genesis Caton Manor altimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Apr 29, Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 1914 1 M 2 1 F 94 220**-**14**-**9840 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 1√Yes 2□No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21217 501 Dolphin Street #313 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: black Completed by 3 → Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Caton Manor Nursing Home 3330 Wilkens Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\Other(Specify) in state 22. Name and Address of Facility or Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Ronald Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. shock, Immediate Ouse (Final disease or condition resulting in death) 3 days Due to (or as a consequence of) Athelosclerus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical Year se of death? Completed by 4 | Unknown ndings available Be Medical Certification: To

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760, After this within 24 hours after death.

To the Funeral Director: A completely filled in by the f

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 21s marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he matter a once.

Physician

/Medical

F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3 □Ectopic				3d. Date of del	livery Day
art II. Other significant conditions	contributing to death but not res	ulting in the underlying	cause given in Part i.		23e. Did tobacco us	se contribute to	the caus
Hypertensien,	asteontmit	in atrial	Li mi lahi	n,	1 Yes 2]No 3∏Pr	robably
Chronic Obstr.	the Pulmone	my Dise	che,_		24a. Was an autopsy		utopsy fin completic
Dialeta mol	Otus.	O			performed? 1☐ Yes 2 No	death? 1 ☐ Yes	2 🗆 N
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examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ [OOA Other: 4 Nursing F	lome	5 ☐ Residence 6	☐Other (Spe	cify)
27. Manner of Death 1 Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d	. Describe how injury	occurred	

6 Could not be determined 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

1 McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12754

Eari WID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 21227 Baltmon RAJA MI 4367 Kollins Form CIEETHA

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per fh 8879 5-20-08 vt. State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Aaron Doughty 1848 2003 MAY 10 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A The Johns Hopkins Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Min. 1 1 1 2 F Yrs 0 Jan 23, 2008 Maryland None Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No Baltimore Md. Anne Arundel 10e. Street and Numbe 10f. Zip-Code 10g. Citizen of What Country? USA 1723 Jacobs Meadow Drive 21144 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Black Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Infant Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tanya M Doughty Aaron Doughty Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1723 Jacobs Meadow Drive Severn, Maryland 21144 Tanya M. Doughty Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Murial 2 ☐ Cremation 3 ☐ Removal from State 05/17/08 Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Futaw Place Baltimore. Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or ceart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PREMOTURITY 24AN 801 disease or condition resulting in death) Due to (or 's a consequence of) DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last HRONIS しろろい Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2XNo 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes X No 1 🗌 Yes 2 🗌 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of . Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical **Examiner** The law requires that the death certificate be executed Box 68760, P.O. of Vital Records, Physician: Division

þ be page 2 should peen has certificate director, this eral Director: After this filled in by the funeral I or Attending P after death. Hospital of 24 hours a Funeral D the the

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Certification:

Medical

29a. Certifier

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29b. Signature and title of certifier

and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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tate Registrar

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

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RES - DOD

1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) BOCS, OI YAM

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JULIA TRINTIS PO

600 NORTH 32. Registrar's Signature

31. Date filed (Month, Day, Year) 19 2008

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For 1_ State	State of	Marylan	•		of Health a	and Me		- Cl	0.08	161	24
			Registrar 1. Decedent's Name (First, Middle	Last)		Cer	uncale	Ji Dealii	1	2. Date of Deat	ng. No. h		3. Time of	Death
п	Physici		Anna M. Fink	, 2007						Month	Day	Year	2:35	p_{M}
	/Medic Examin		4a. Facility Name (If not institution	, give street and num	ber)		4b. City, Tow	n, or Location of	of Death	05/14/2		inty of Death		
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	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ XF	7. Age (In yrs.		If Under 1 Y Months Da	ear If Under	24 Hrs. Min.	8. Date of Birth (Month, Day, 04/14/1	Year)	9. Birth Cou	place (State ontry)	r Foreign
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	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside Ci	ty Limits
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	tems	Funeral Director	11. Marital Status	12. Was Dece Armed For	ces?	.S. 13. \	Was Decedent f Yes, specify	of Hispanic Ori Cuban, Mexican	gin? (Spec 1, Puerto F	cify Yes or No- Rican, etc.)		Race - Amer Black, White		
36	rs aft	by F	1 ☐ Never Married 2 🔀 Marri 3 ☐ Widowed 4 ☐ Divorced	led 1 ☐ Yes If Yes, Give Year or Da	9		1⊡Yes 2⊠	No Specify:			Spe	ecify: Whi	te	
21215-0036	within 72 hours after death with the Maryland one. Than "natural", or Items 23a or 28a-f ehow he Madical Examiner must be notified at	ted	15. Decedent	's Education		16a. Deced	dent's Usual O	ccupation			16b. Kind o	f Business/I	ndustry	
215	thin 7.	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-	-4or 5+)	lite.	DO NOT use re	one during mos etired)	t of workin	g				
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Maryland	be fill Hall H	Be	17. Father's Name (First, Middle,						ose I	(First, Middle, I	Maiden Sur	name)		
2	hould d Mer marke matic	ဥ	Vincent Marant 19a. Informant's Name/Relationsl			19h Mailir	a Address (St	reet and Number			City or To	un State 7i	n Code)	
Z	id 2 s Ith an 27 is i		Mrs. Mildred I		ughter)		•	Creek R						1617
ē,	tem ?		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name o	of .				on - City or T		
9	Pages ent of nt: If I		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State I		ark Cem		05/16	5/2008	Balti	more,	Maryla	and
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Bright if them 27 is marked other than "natural," or teams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be refulled at another.		21. Signature of Funeral Service			22	. Name and A	ddress of Facilit	y Hi	ıbbard E	unera	1 Home	- Inc.	
Õ	Deporting of the popular of the popular is any is		Mark T.	3		4	107 Wi	lkens A						
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca	used the deat ach line.	h. Do not ent	er the mode of	dying, such as	cardiac or	respiratory arr	est,		Approximat Interval Bet	ween
	Physician	6.1	Immediate Cause (Final disease or condition	Con	eseu	e We	eing F	Zeulur	e			3	Onset and	Death
	/Medical Examiner		resulting in death)		a conseq		8	2	55				51	
		_	Sequentially list conditions	b. CVV	Trees	UAO	rece	Scene	22N)			-	114	4
	nsit	ulu ulu	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury		m CD.		FAM.	_					2.	
Ć,	te be executed ysicien and le burial-transit	Examiner	that initiated events resulting in death) Last	U	or as a conseq		~ 100.	<u> </u>				-		
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Вох	ath ce	Physiclan/M	23b. Was decedent pregnant in the past 12 months?		rth 2 ☐ Feta	I death 3	Ectopic pregr				23d.	Date of delin		Year
o. _	he de	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4⊟Pregna 9⊟Unkno	ant at time of d wn	eath 5L	Other (specif	у)						
σ.	w requires that the death certific been signed by the etlending p should be detached for use as	/ Ph	Part II. Other significant condition	ns contributing to de	ath but not res	ulting in the u	nderlying caus	e given in Part I		23e. Did to	bacco use	contribute to	the cause of	death?
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S	s bee	Completed								24a. Was a		4b. Were aut	opsy findings	available
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	Physicien: r this certifice rat director.	2	1 ☐ Yes 2 📈 No			ER/Outpatier				ne 5 Reside			ify)	
Ĕ	ing P	lon:	27. Manner of Death 1/2-Natural 5 ☐ Pendin	9	of Injury h, Day Year)	28b. Time of Injury	M 28c.	Injury at Work?		8d. Describe h	ow intury or	curred		
Division of	Attending or death. ector: After by the fune	licat	2 Accident investig 3 Suicide 6 Could r	not be 200 Bloom	of Injury - At he	ome, farm, str				8f. Location (S	treet and N	u <i>mber</i> or Ru	ral Route Nun	nber.
.≥	To the Hospital or Attending Physicien: within 24 hours stee death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification;	4 Homicide determ	buildir	ng, etc. (Specif	y)				City or Town	n, State)			
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier Certifyin	g Physician: To the	best of my kno	Medge, deat	h occurred at t	he time, date ar	nd place, a	nd due to the c	ause(s) and	manner as	stated.	
	the Ho in 24 the Fu	edical	(Check only 2 Medical one)	Examiner: On the ba	er stated.	ition and/or is	stigation, in	my opinion, dea	ith occurre					5)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	KD	1	///	29c. Li	cense number		2	!9d. Date si	gned (Month	Dey, Year)	1.0
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	4		30. Name and address of pelson.	completed caus	e of death (Item	723a) (Type,	Print)	la a	Q 1	Lihn	a 10	ر د	121	111
	Sta	te	31. Date filed (Month, Day, Year)	DE. RI	egistrar's Signa	ure du	court	neine	لاياد	1	2110	ues-ev	when	VILLY_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 2008 /Medical 4c. County of Death 4b/City, Town, or Location of Death 4a. Facility Name (If not institution, give street and r **Examiner** 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrd. last birthday, **Funeral** Min Months Days Hours 1 ☐ M 2 【 F Yrs. 5 North Carolina Director of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director nore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral \propto d 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ②No Specify. þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) ast Carolina Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be eman Csister 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Nown, State, Zip Code) TO 05 1-6 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 🕅 Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility To Seph Ryss 222 W. North 21. Signature of Funeral Service Litensee Joseph 23a. Part 1. If her the displayer, or complication. That cause it has shoot, if r heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** elmers /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) ☐Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No ′ s certificate has be lirector, page 2 s 1□ Yes 2. No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 □ ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year, Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

> State Registrar

DHMH 17 Rev 1/2001

SAMB ANDAY 31. Date filed (Month, Day, Year) MAY 1 9 2008

29b. Signature and title of certifie

29a. Certifier

(Check only one)

Wilkems AUT BASKARAN 3455 32. Registrar's Signature

arkarana

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2164

29d. Date signed (Month, Day, Year)

MD 21229

Box 68760, P.O. Records, Division of Vital

sician and Physician: The law requires that the death certificate be executed physician the burial has After or Attending death. To the Hospital or Attendl within 24 hours after death.

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Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or itel

Baltimore, Maryland 21215-0036

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year) #AY 1 9 2008

1,5WTT

29b. Signature and title of certifier

DEMOLUNG



and manner stated.



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEMSLUNE 1, SWT MD 5601 LOCH NAWW BLVD SMT MUNE, MD 31239

29c. License number

D15135

29d. Date signed (Month, Day, Year)

MAY 15, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 15, 2008 **Physician** 3:45 A M Leola M. Gaither /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carrol1 Westminster Summerville Assisted Living 8. Date of Birth March 2, 1921 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Maryland 1 □ M 2 🖾 F 87 217-16-4353 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Experiment must be notified at once. 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Director Maryland Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21157 United States 45 Washington Rd Funeral 14. Race · American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2K Married Specify: White Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leola Lainhart ဂ္ James Atwood Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 309 Snowfall Way; Westminster, MD 21157 Son John T. Gaither, Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Airy, Maryland 5-19-2008 Poplar Springs 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature profal Service ten 101290 1630 Edmondson Avenue; Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart trillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (nat disease or conditi resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2x No 3 Probably 4 Unknown 1 ☐ Yes certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

State Registrar 29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, Year)

MAY

2008

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Vollerela

23a) (Type, Print)

of death (Ite

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Waryland Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death 700 **Physician** AM JAMIA GILLIS 2008 05 15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2017 N. Payson Street
5. Social Security Number 6. Sex 7. Ag Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗷 F 21 219-17-4855 198 MARYLAND Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaluate it ust be notified at any Injury or other traumatic event, the Medical Evaluate it ust be notified at any Injury or other traumatic event, the Medical Evaluate it ust be notified at any Injury or other traumatic event, the Medical Evaluate it uses the notified at any Injury or other traumatic event, the Medical Evaluate it uses the notified at any Injury or other traumatic event. 1 X Yes 2 □ No Director MD Baltimore N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21217 2017 N. Payson Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) A Elementary/Secondary (0-12) Unemployed Unemployed 11th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Be Barbara King Bobby Gillis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3224 Elmey Avenue Balto, MD 21213 19a. Informant's Name/Relationship (Type. Print) Cynthia King - Aunt 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-20-2008 Balto, MD Carmel Cem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Light 22. Name and Address of Facility March F/H East 21202 1101 E. North Avenue Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** EARDIORESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** END-STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed HIV INFECTION burial-tran Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐Yes 2 No 9 Unknown cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural
2 ☐ Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No n 24 hours after dea se Funeral Director bletely filled in by th 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number PHYSICIAN D0058090 2008

Registrar DHMH 17 Rev 1/2001

State

WOLFEST , BALTIMORE

21287

200 N.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIBERRY, MD

GEORGE K.

31. Date filed (Month, Day, Year)
MAY 1 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State o	f Marylai		artmen			and M	lental Hyg	iene	08	16129
	Physici	20	Decedent's Name (First, Middle	e, Last)	^						2. Date of Dear Month	th Day	Year	3. Time of Death
	Physici /Medic		Evelyr	H.		don	,				5	<u> </u>	2003	10:40PM
	Examin	er	4a. Facility Name (If not institution	1	mber)			- 1	Location o	of Death		4c. Coun	ty of Death	•
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	Funeral Director		5. Social Security Number 143–10–8094	6. Sex 1 ☐ M 25 ☐ F	7. Age (In yrs	. <i>iast birthday)</i> Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day) July 8,	Year)	9. Birthp Coun	lace (State or Foreign lity) Jersey
			Usual Residence of Decedent		91						July 0,	1710	Tren (<u>Jerbey</u>
	yian how		10a. State 10b. County		10c. C	ity, Town or Lo	ocation						1	0d. Inside City Limits
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	ith th)ire	10e. Street and Number				10f. Zip				1	0g. Citizen o		itry?
	ath w	Funeral Director	117 Heron Poi						.620			US	6A	
	itams	nue	11. Marital Status	Armed Fo		J.S. 13.	Was Deced If Yes, spec	ent of Hi	ispanic Ori n, Mexican	gin? (Spe 1, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ lack, White,	
36	rs aft	byF	1 Never Married 2 XMarr 3 Widowed 4 Divorced	ied 1 □ Yes If Yes, Gi Year or D	ve		1 □ Yes 2	2 ∏ No	Specify:			Spec	ity: whi	te
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<u>Y</u> a	ould I Men parka	P	Walter Herber								Helen He			
Maryland	od 2 sh Ith and 27 is m r traum		19a. Informant's Name/Relations Douglas Gordo				ng Address 211y I				Al 2620		n, State, Zip	Code)
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Records,	Attanding Physician: The law requires that the death certificate be executed rideath. r death. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit			<u>- </u>							1 □ Ye	s 2 No	3 🗌 Prob	ably 4 □Unknown
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Ita	iclan: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only on	/		
<u>></u>	Physic this co	မ	1 □ Yes 2 No			ER/Outpatier			4 KNU	rsing Ho	me 5□Reside	ence 6 🗆 O	ther (Specify	1)
Division of Vital	Attanding Ph or death. actor: After th by the funeral	lon:	27. Manner of Death 1 Natural 5 ☐ Pending		of Injury th, Day Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe ho	w injury occu	urred	
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<u>></u>	al or A after Pirac d in by	Certification:	4 Homicide determine	buildi	ing, etc. (Speci	ify)	eet, ractory	, onice			City or Town		nder or Aura	i moute ivamber,
	To the Hospital or Attanding I within 24 hours after death. To the Funaral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the Examiner: On the b and man	best of my knoasis of examination	owledge, death ation and/or in	n occurred a vestigation,	at the tim in my op	ie, date and pinion, deal	d place, th occurr	and due to the ca	ause(s) and nate and place	manner as st e, and due to	ated. the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** MARYRUTH **GIBLIN** 15, 2008 7:15A May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore The Maples 7925 York Road Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day 1923) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Michigan 84 215-14-0531 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2XXNo Director Maryalnd Baltimore Towson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21286 USA 7925 York Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2000No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 □ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes XX No Specify: \$ 3XXWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marguerite Matthews Albert Edward Konkle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Palmer DTR 606 Overbrook Road Baltimore, Maryland 21212 20a. Method of Disposition
1 ☐ Burial A Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) GreenMount Crematory May 16, 2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Time Inc Signature of Fund 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KINDS EMPHY SEMA **Physician** /Medical Due to (or as a consequence of): **Examiner** RUMONARY DISEASE CHROMIC OBSTRUCTION Sequentially flot conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 5 signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of was a autopsy performed death? 1 ☐ Yes certificate 1∐ Yes 2 □ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: ₽ 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date şigned (Month, Day, Year) D0020795 S008 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DR. STE 113 TOWSON IND ZIZO4 JOHN G. LANIN Con 1600 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

MAY 1 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Georgia Green May 9, 2008 1:45 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Gilchrist Center for Hospice Care 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 □ F Min Yrs. Director 227-20-3626 Oct 22, 1917 Virginia Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, its I'le Jical Examinat must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3801 Schnaper Drive 21133 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ltimore, Maryland 21215-0036 ģ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify Specify 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Duty Nurse 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie Blackstone Eva Blackstone ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is I 2815 Rona Road Baltimore, Maryland 21207 Stella Satchell injury or other permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Surial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 05/15/08 Baltimore, Md. Woodlawn Cemetery & Chapel 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1309 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part . Enter the sease, or combinations that caused the deat . Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a conse lence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 110 Examine Due to (or as a consequence of): be executed burial-transi and Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) the 2 No 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ icate has been sign, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy certificate performed' 2 No 1 ☐ Yes 2 🗀 No 1 ☐ Yes Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of this Certification: To reen After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

6701 Registrar's Signature N-Charles St. Balto, md 21208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician Grace Gaither** 2008 /Medical 4a. Facility Name (If not institution, give street and number City, Town, or Location of Death 4c. County of Death Examiner N/A Tal 5. Social Security Number Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Min. Days 1 ☐ M 2 ☐ F Yrs Director Marvland Dec 16, 1934 213-30-2394 73 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director Baltimore N/A Maryland 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? U.S.A. 21218 2200 Homewood Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 ↓ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired)
 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than Elementary/Secondary (0-12) Sun Dry Cleaners College (1-4or 5+) Presser 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pinkey Howard Oliver Garrett ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5509 Windsor Drive Temple Hills, Md. 20748 Sharon Garrett 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of H Important; If it any Injury or c 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 05/09/08 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Sign the of Funeral Service 22. Name and Address of Facility Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician /Medical resulting in death) Due to (or as a consequence of) Examiner eumonia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Estevetive tulminary Disease requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of Vital Records, P.O. Box 68760, physician Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached the q∏Unknown 9 Unknown á signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 1 🗌 Yes 2 □ No 4 []Unknown page 2 should Completed reen The lav 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has certific te 2 **1** No Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 3□ DOA 1 Tyes 1 Inpatient Certification: To 2 ER/Outpatient or this the funeral 27. Manner of Death 28a Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident death 24 hours after death e Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. the 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Dav. Year)

State Registrar 31. Date filed (Month, Day,

6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Year)

32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** reene /Medical 4c. County of Death 4a. Facility, Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 💢 F Months Davs Hours 54-490 North Director Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 XYes 2 □ No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? APT. or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify 3 ☐ Widowed 4 ☐ Divorced "natural", a Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. Bulto.C 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be een 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (daughter) permit. Pages 1 and 2 a Department of Health an Important: If item 27 is any Injury or other trau once. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 3 Removal from State Green Mount 21. Signatore of Funeral Service Licenses 23a. Part f. ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a confequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 mon Day 4☐Pregnant at time of death P.0. ed by the a detached f 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy page The perform this certificate or Vital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 10 2 ER/Outpatient 3 DOA To 1 Inpatient within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 00 30. Name and ad ass of person who completed cause of death (Item 23a) (Type, Print) Mart 44 1600 W.

DHMH 17 Rev 1/2001

State Registrar 31. Date tiled (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2008 Year **Physician** Nicholas Gialamas 15, 3:55PM May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 6. Sex 1**X** M 2 ☐ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 232-62-8597 74 2-12-1934 Greece Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director MD Harford Kingsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21087 2513Karylou Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Painter Industrial Constr. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marino Gialamas Angela Dre ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacia Gialamas - Wife 2513 Karylou Dr., Kingsville, MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 5-19-08 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton FUneralHome, FridoT PA, 2134 Willow Spring Road 21222 23a. Part1. Enter the disease, or complications that each death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) endocarditis **Physician** DACterial weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate erse 1∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 1 Natura 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar

29b. Signature and title of ceglifier

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Year) 7

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32. Pagistrar's Signature

DHMH 17 Rev 1/2001

29c. License number

25201

29d. Date signed (Month, Day, Year)

V. Charles St. Balto and ZIZIX

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 6 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9:00 AM **Physician** 12 2008 alvin /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours Min. 220-20-2498 MDirector permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 □ No altimore Funeral Director 10g. Citizen of What Country? 10e. Street and Number a1a01 . Franklin Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Blac Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) altimore 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Franklin St. Baltimore MD 2120]
Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State on Forest 5/20/2008 Baltimore MI)
22. Name and Address of Facility Vougna C. Greene Fundral Services 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service L icense 4905 York And Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Distase YEIVS Physician Due to (or as a consequence of): /Medical **Examiner** Diabetes Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed pertension and as a consequence of): Due to (or ed by the attending physician detached for use as the burial Division or Vital Records, P.O. Box 68760, Renal alluve Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1□ Yes 2 No death? 2□ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: Hospital: 2 No 4 Nursing Home 5 Residence 6 □Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 29c. License number 29d. Date signed (Month, Day, Year) D0050500 who completed cause of death (Item 23a) (Type, Print) BALTIMORE STREET STREET B 10 NOKTH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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MAY

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 8 2008 **Physician** 1:05 PM SONDRA RITA HIGGINS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 23, 1932 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🗓 F Michigan 75 Director 384-30-3248 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Kensington Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4010 Simms Drive 20895 U.S.A. Pages 1 and 2 should be filed within 72 hours after death anent of Health and Mental Hygiene.
wit: If item 27 is marked other than "natural", or items 23.
Iny or other traumatic event, the Medical Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Defense Executive Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olivia Rita Bombard Rogero Bernardi 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4010 Simms Dr., Kensington, MD 20895 Jennifer Meshalam (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/15/08 Mt. Morris, MI Flint Mem. Park 4 Donation 5 D Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Sharp Funeral Home & Cremation Center Þ 6063 Fenton Rd., Flint, MI 48507 Moune 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE CORONARY SYNDROME **Physician** /Medical Due to (or as a consequence of): Examiner CARDIOPULMONARY FAILURE Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed RENAL FAILURE use as the burial-trar and Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performe death? 1 ☐ Yes 2□ No 2 X No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one)

State

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Registrar

29b. Signature and title of certifier

LISA M. PALACHECK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. ne

USN

MC32. Registrars Signatu 29c. License number

M-5427 (TX)

NATIONAL NAVAL MEDICAL

BETHESDA MD 20889-5600

29d. Date signed (Month, Day, Year)

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CENTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 A M William May 14, 2:05 Hiester /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 6336 Cedar Lane #347 Apt. Columbia Howard 8. Date of Birth (Month, Day, Ye Dec. 14, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** Year) Months Days Hours 1**X** M 2□ F 90 1917 Pennsylvania Director 187-10-5529 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at 1 XYes 2 ☐ No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. #347 6336 Cedar Lane U.S.A. 21044 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 △Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2XNo "natural", or If Yes, Give Year or Dates: 12 Years Specify: 2 Specify: 3 Widowed 4 Divorced White Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Invaloration." 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Government Worker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William F. Hiester Mary Emmert မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6336 Cedar La. Apt. #347 Columbia, MD 21044 Hilda Hiester (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 3/15/08 Alexandria, VA 21. Signature of Funeral Service Lio-risee 22. Name and Address of Facility 33064 Society Andrews Ave Ext, Pompano Beach, Neptune 3404 NO. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed aftending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.0. signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 1 ☐Yes 2 📉No 2 No Division of Vital 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatare and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) Name and address of person who

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State Registrar 31. Date filed (Month, Day, Year)

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2008

32. Registrar's

8-03643 David

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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avid Heyde			of Maryland / Departme	ent of Health ate of Death	and Mental Hygie	Reg. No.	April 1	
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j	4a.	Facility Name (if not institution, give Good Samaritan Hospital	street and number)	Baltimor	re		No acc	halana (State of
Samuel		Good Sattlattati 1 1035 feet Social Security Number 6. Sex	7. Age (In yrs. last birt	hday) If Under 1 Months	Year If Under 24Hrs. 8. Days Hours Min.	Date of Birth(MM/I	Foreig	11
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15-0036 filed within 72 hours after death with the Maryland Hygiene. And other than "natural", or items 23a or 28a-f show in the Medical Examiner must be notified at once.	11	. Marital Status Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes No	If Yes, specify	Cuban, Mexican, Fuerto Nic	an, etc.)	White, etc.	Nhito
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Box 6876(e death certificate the attending phy ed for use as the t	ian/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of deat	2 Fetal death				
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Functor After this certificate has been signed by the attending physical particle of the funeral director, page 2 should be detached for use as the b	Sol	25. Was case referred to medical	T		26.Place of Death (Check		esidence 6	Other:
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Ph	nysician: To the best of my knowledge miner: On the basis of examination a and manner stated.	ge, death occurred at nd/or investigation, in	the time, date and place, ar my opinion, death occurred	d due to the cause at the time, date a	nd place, and du	ue to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 2008 1613

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9500	ges 1 and 2 should be filed within 72 hours after death with free Maryland it of Health and Mental Hygiene. 14 of Health and Mental Hygiene. 15 of Health and Mental Hygiene. 16 of other traumatic event, free Peopleal Examilinar must be notified at or other traumatic event.	by Funeral	11. Marital Status 1 ☐ Never Mar 3 ☐ Widowed	ried 2 X Marrled 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:			Vas Decedent Yes, specify (□Yes 2☐	of Hispanic Orig Cuban, Mexican, No Specify:	gin? (Spec , Puerto R	cify Yes or No- lican, etc.)		14. Race - Ame Black, Whit Specify: W		
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and	The second secon	To Be	Donal	d Ray Elm	er				E	emma .	Jean Hu	ırst			
Mary	alth and N			Name/Relationship (**	19	b. Mailin	g Address <i>(St</i> 7 Guilf	reet and Numbe ord Roa	er or Rural ad, Je	Route Numbe	er, City o	7 Town, State, 20794	Zip Code)	
baitimore,	permit. Pages 1 and 2 g Department of Health a Important; if item 27 Is any Injury or other trau				Removal from State	1		sition (Name of natory or other Cemeter	1 -	May 2	O,		cation - City or channon		
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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 16140

Secretary Number Country Count		CKS 1-F	State Of Maryland	Certificate of	of Death			g. No.	C Time of Dooth
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21. Signature of Fundamis Service Locations 12.00	ben 2	e T	1. Warital States	rces?	If Yes, specify Cuban	Mexican, Puerto	Rican, etc.)	"""	
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30. Name and address of person who complèted cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Manth, Day Year) 1018	After this certificate ha funeral director, page 2	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. P (Spect only one) 2 Medical Examiner:On the ba and mann	ate of Injury 15, 2008 Place of Injury - At home, fa cify) Single Family best of my knowledge, dea sis of examination and/or in	tripatient 3 DOA Time of Injury 28c. I hrs 1 Timm, street, factory, offinath occurred at the time investigation, in my op	Other ₄ N Injury at Work? Yes 2 N ce building, etc.	lursing Home 28d. Des Subject 28f. Loca 27 2201 Ga	cribe how injury of shot by policition (Street and Nown, State) sylawn Drive, Late cause(s) and man, date and place,	occurred Ce Number or Rural Route Number ansdowne, MD anner as stated. and due to the cause(s)
Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Balantors, MD 2. State 31. Date filed (Marth, Day Year) 1008	After this certificate ha funeral director, page 2	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. P (Spect only one) 2 Medical Examiner:On the ba and mann	ate of Injury 28b. T 1430 Place of Injury - At home, fa 26/19/ Single Family best of my knowledge, deasis of examination and/or inter stated.	trpatient 3 DOA Time of Injury 28c. I hrs 1 Time, street, factory, offine of the time o	Other North	lursing Home 28d. Des Subject 28f. Loca 27 2201 Ga	cribe how injury of shot by policition (Street and hown, State) sylawn Drive, Late cause(s) and me, date and place,	Number or Rural Route Number ansdowne, MD anner as stated. and due to the cause(s) e signed (Month, Day, Year)
State 31. Date filed (Manth, Day, Year) 32. Registrar's Signature	After this certificate ha funeral director, page 2	Certification: To Be	25. Was case referred to filed care examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physician: To the one) 2 Medical Examiner: On the ba and mann 29b. Signature and title of certifier	ate of Injury 28b. T 1430 Place of Injury - At home, fa 26fy) Single Family best of my knowledge, deals of examination and/or interstated.	trpatient 3 DOA Time of Injury 28c. I hrs 1 Time, street, factory, offine of the time o	Other North	lursing Home 28d. Des Subject 28f. Loca 27 2201 Ga	cribe how injury of shot by policition (Street and hown, State) sylawn Drive, Late cause(s) and me, date and place,	Number or Rural Route Number ansdowne, MD anner as stated. and due to the cause(s) e signed (Month, Day, Year)
State St. Date life Willy 19 2008	To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2	Certification: To Be	25. Was case referred to filed the sex miner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physician: To the one) 29b. Signature and title of certifier 30. Name and address of person who completed	ate of Injury 28b. T 1430 Place of Injury - At home, fa 27/7) Single Family best of my knowledge, deals of examination and/or inverstated.	tripatient 3 DOA Time of Injury 28c. In 1 Timm, street, factory, offi ath occurred at the tim nivestigation, in my op 29c. Li C	Other4 N Injury at Work? Yes 2 N ce building, etc. e, date and place inion, death occu- cense number 0.C.M.E.	lursing Home 28d. Des Subject 28f. Loca or T. 2201 Ga e, and due to th	cribe how injury of shot by policition (Street and hown, State) sylawn Drive, Late cause(s) and me, date and place, 29d. Date May 1	Number or Rural Route Number ansdowne, MD anner as stated. and due to the cause(s) e signed (Month, Day, Year)
	To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2	Certification: To Be	27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specific Check only one) 29a. Certifier 1 Certifying Physician: To the ba and mann 29b. Signature and title of certifier 30. Name and address of person who completed Tasha Greenberg MD. Assistan	ate of Injury and 28b. T 1430 Place of Injury - At home, facility Single Family best of my knowledge, dealers stated. Cause of death (Item 23a) at Medical Examiner	tripatient 3 DOA Time of Injury 28c. In 1 Timm, street, factory, offi ath occurred at the tim nivestigation, in my op 29c. Li C	Other4 N Injury at Work? Yes 2 N ce building, etc. e, date and place inion, death occu- cense number 0.C.M.E.	lursing Home 28d. Des Subject 28f. Loca or T. 2201 Ga e, and due to th	cribe how injury of shot by policition (Street and hown, State) sylawn Drive, Late cause(s) and me, date and place, 29d. Date May 1	Number or Rural Route Number ansdowne, MD anner as stated. and due to the cause(s) e signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MAY Day 16, 2008 8:48A **Physician** Catherine Honemann /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Saint Joseph Medical Towson Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Min 1 □ M 2**X**X 5, 1919 Maryland Oct. 212-18-2840 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County fshow a or 28a-f show the notified at 1 ☐ Yes 2 X No Timonium Directo Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21093 ral", or items 23a Examiner must b 2300 Dulaney Valley Road by Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: Baltimore, Maryland 21215-0036 3 ☐Widowed 4 ☐ Divorced White "natural", Completed 16b. Kind of Business/Industry nt of Health and Mental Hygiene. If item 27 Is marked other than "natur or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking 12 Senior Accounta<u>nt</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Blake Marie Henry ٩ George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21212 602 Stoneleigh Road Elmer H. Wingate, Jr. Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or Hilltop Service Corp. 5-17-2008 Maryland Towson 4 ☐ Donation 5 ☐ Other (Specify) Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Towson, Maryland 21204 1050 York Road au 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MINUTES Immediate Cause (Final RESPIRATORY ARREST **Physician** resulting in death) /Medical Due to (or as a consequence of): YEARS Examiner CORONARY ARTERY DISEASE Se rentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (vi as a consequence of) Examine al or Attending Physician: The law requires that the death certificate be executed a stread that. In Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide filled in within 24 hours af To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

State Registrar

29b. Signature and title of certifier

BEAUVOIS

OSLER DRIVE.

M.D.

7601

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D62551

TOWSON.

29d. Date signed (Month, Day, Year)

MARYLAND 21204

16,2008

Registrar DHMH 17 Rev 1/2001 29a. Certifier

(Check only one)

29b. Signature and title of certifier

ORIGINAL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

D45757

Ecrtifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

12,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4240 Eastern Ave Balt, MO 21224

Matthew Mc Nahney

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 23 AM Physician George V. Imhoff 08 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltmor Franklin Square Hospital -osedate 8. Date of Birth (Month, Day, Year) 04-01-1917 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 🕅 M 2 🗆 F MD Yrs. 216-10-2679 91 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mast be recitled at 1 ☐ Yes 2√√No Director Baltimore MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number TISA 4317 50th Avenue 21236 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Maryland/21215-0036 1 ☐ Yes 2 🗓 No Specify: White If Yes, Give Year or Dates Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Asst. General Foreman **BGE** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George W. Imhoff Mary Vaughan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4317 50th Avenue Baltimore, MD 21236 Marion B. Imhoff (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05-21-2008 Parkwood Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary **Physician** edemo /Medical Due to (or as a cons quence of): Examiner Vernolcular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending physic for use as the b 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) □Yes 2□No ed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by in sufficiency 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 ☐ Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊠No 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) 1 XNatural 5 ☐ Pending investigation М 1 ☐Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the fu death. 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5/18/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar Sunge | Dhana

MAY 1 9 2008

31. Date filed (Month, Day, Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** David Weslev Kuhn 2008 May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Sykesville Fairhaven Birthplace (State or Foreign Country) if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 7 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □XM 2 □ F 91 184-16-7611 Yrs. 1916 PA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 No 2 No Sykesville MD Carroll Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21784 U-404 7200 Third Avenue Funeral 14. Race - American Indian, . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 TyYes 2 □ No WWII if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) law enforcement Elementary/Secondary (0-12) College (1-4or 5+) police officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olive Herring David Wesley Kuhn Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5942 Jumpers Ct., Salisbury, MD 21801 Linda Tilghman (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State All County Cremation | 5-15-08 Sykesville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Daige Haught Sperbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and the Funeral Director. attending physician and to for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. if yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No neral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2 12 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of gertifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

2008

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9, 2008 Kazimiera Kellman 5:30 PM May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Stella Maris Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F Yrs. 231-42-5973 88 26, Feb. 1920 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Expriring must be notified at once. 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 900 S. Rolling Road 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2K No Specify ş 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unknown unknown unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Louis Weinkam, Jr. Guardian 1002 Frederick Road; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park 05/19/2008 Woodlawn, Maryland Other (Specify) 4 ☐ Donation 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of uneral Service L M01290 23a. Part 1. Enter the dijease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fry ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (First disease or condition resulting in death) **Physician** ASPIRATION PNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 ☐ Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2X No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 1 Other (Specify) 1 ☐ Yes 2 🛣 No HOSPICE Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 X Natural
2 ☐ Accident 5 Pending 1 □Yes 2 □No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Records, Vital ō To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Division

Baltimore, Maryland 21215-0036

68760,

Box

P.O. I

2008

State Registrar

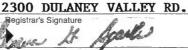
DHMH 17 Rev 1/200

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2008

30. Name and address of person who completed cause of death (Iem 23a) (Type, Print)

29b. Signature and title of certifie

DR. ERNESTINE WRIGHT



29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 08:47AM MAY KIPP 5 2008 1ERNON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BAYVIEW MEDICAL CENTER JOHNS HOPKINS If Under 1 Year | If Under 24 Hrs Months Days Hours Mir 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** Months 1 XM 2 □ F January 11,1940 Maryland Director 220-36-2647 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b, County 1 Yes 2 No Dundalk Maryland | Baltimore Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 USA 203 Parkwood Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Saltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) General Motors Assembly Line Worker 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George W. Kipp Leotta F. Schmaezle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 203 Parkwood Road, Dundalk, Maryland wife Marge Kipp 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition May 19,2008 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland Oak Lawn Cemetery 4 Donation 5 Dother (Specify) Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21 Signature of Funeral Service Ucense 21222 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEARS **Physician** CONGESTIVE /Medical Due to (or as a consequence of): Examiner ISCHEMIC CARDIOMYOPATH if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760. physician s the burial Physician/Medical attending pl 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. detached 9 Unknown by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy certificate has page 2: perform 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3□ DOA 1 ☐ Yes 2 ER/Outpatient ၉ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this of the Funeral Director; After this ompletely filled in by the funeral directors. 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Matural Injury at Work? Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

Harris, MD

ELIZABETH HARRIS

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

2008

32. Registrar's Signature

4940 EASTERN AVENUE, BALTIMORE, MD

RES - 000

MAY 15, 2008

08-03695 Marvin Lucas, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 76147

		For State		Certifica	ate of l	Death				eg. No.		3. Time of Death	
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h the		314 South	SOCIA C	4 Francis II S	13 Was	Decedent of His	nanic Origin	n? (Speci	ify Yes or N			erican Indian, Black,	
death with the Maryland or items 23a or 28a-f show any must be notified at once.	ē	11. Marital Status 1 Never Married 2 N	Armed Forces	? _	If Ye	s, specify Cuban,	Mexican,	Puerto Ri	can, etc.)	- 1	White, etc.		- 1
ਨੂੰ ਵਿੱਚ	Funeral		1 Yes 2 vorced If Yes, Give Year	CNO	1	Yes 2 (No	specify:			s	pecify: B	kack	- 1
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5-0036 led within 72 hours after death with the Maryland Hygiene vinth the "natural", or items 23a or 28a-f sho- the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) Conces (1 7 s.	,	1	SUOV				1	Non	0	
5-0036 ed within 73 tygiene. other than the Medical	E	17, Father's Name (First, Middle	a Last)			SON	18.Mother's	s Name (F	irst, Middle	Maiden S	urname)		
21215-0036 uld be filed within 72 hours after Mental Hygiers marked other than "natural", c event, the Medical Examiner:		A Cocio	5,000	_			M	en	dora	W	11501	\cap	
2121! uld be fill Mental F marked c event, i) Be	19a. Informant's Name/Relation	ship (Type, Print)	19	9b. Mailing	Address (Stree	t and Num	ber or Ru	ral Route N	umber, City	y or Town, St	ate, Zip Code)	
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tore, MD ages I and 2 sho nt of Health and t: If item 27 is other traumati			on 3 Removal from S	State	atory or oth		ļ	50	12.200	a a	- ilia	nore MD	
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Baltimore, permit. Pages I ar Department of Hec Important: If ite injury or other tr		21. Signature of Funeral Service	e Licensee						inn c	ree	4D 2	rol & roice	ا (د
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Physician		23a. Part I. Entertile disease, failure. List only one caus	se on each line.		not enter t	ne mode or dying,	5557.45		,			Between Onse Death	t and
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of V ing Phy After th			28a. Date of		3b. Time of	Injury 28c. In	jury at Wor	rk?	28d. Descr Subject s	be how in	jury occurred		
ding		1 Natural 5 F	ending May 14, 20	008 2	046 hrs	1	Yes 2	No					
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Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending To the Funeral Director: After this certificate has been stand to the funeral director masse? should he detached for use as	completely lifted in by the tunesal	3 Suicide 6 0	ould not be	Local Street					300 South	n, State) Dallas C	ourt, Baltin	nore, MD	(1)
ospit. hour hour	ا ا		Di visione To the boot o	f mu knowledge	death occ	surred at the time,	date and p	olace, and	due to the	cause(s) a	nd manner a	s stated.	
in 24 he Fu	Medical	(Check only one) 2 Medical	Examiner: On the basis of	examination and	or investig	jation, in my opini	on, death o	occurred a	at the time, o	date and p	lace, and due	e to the cause(s)	
Tot Tot	No.	29b. Signature and title of ce	and manner stat	ted.			nse numbe					(Month, Day, Year)	
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H	1	3 Name and address of pe	rson who completed cause Assistant Medical		رم 111 Per	nn Street, Bal	itimore, l	MD 212	201				
١		Laron Locke MD.		istrar's Signature	- 40	_							
	Stat	e 31. Date filed (Month, Day, Y	ear)	isu ai s signacule	4000								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 16168 08-03689 State of Maryland / Department of Health and Mental Hygiene Jerome L. Langan 1- For State amend #18&19b Per FH 688 #ic 7 #03 #/08 at #H Rea. No. 3. Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day May 14, 2008 1715 hrs Physician/ Jerome L. Langan Me Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N. Luzerne Avenue **Baltimore** Date of Birth (MM/DO/YYYY) 9. Birthplace (Stata or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Funeral k Days Months Country) MD 1-31-1936 Director 72 1 X M 2 F 212-34-0743 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Y Yes 2 No ıny Baltimore MD Baltimore, MD 21215-0036
pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Frediata and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country Director 10f. Zip Code 10e. Street and Number USA 21224 443 N. Luzerne Avenue 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status

1 Never Married 2 Married 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Yes White 1 Yes 2 X No specify: If Yes, Give Year 3 Widowed Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) ģ 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) School. Teacher 18. Mother's Name (First, Middle, Maidea Surname) 17. Father's Name (First, Middle, Last) Catherine Beckof 19b. Mailing Agenta Street and Number or Rural Route Number, City or Town, State, Zip Code) Be Thomas Langan 19a. Informant's Name/Relationship (Type, Print) 6722 Summa Rambo Ct Columbia, MD 21045 Eileen Rodberg (Niece) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State MD Baltimore, 05-19-08 Most Holy Redeemer 4 Donation 5 Other Specify 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 9705 Bel Air Rd Baltimore, MD 21236 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and vsician Oeath failure. List only one cause on each line. a. Atherosclerotic Cardiovascular Disease ladica. Immediate Cause (Final disease Examiner Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Oue to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDEPME, 9880 6/24/08 TI UNPENDEO attending physician or use as the burial 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Day Month 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Fetal death Live birth Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown Records, P.O. φ 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of autopsy performed? death? this certificate has Yes 2 V No 26.Place of Death (Chack only one) 25. Was case referred to medical t Hospital or Attending Physician: 24 hours after death. Division of Vital Be Other Nursing Home 5 Residence 6 Other: Scene Hospital: examiner? DOA ER/Outpatient 3 Inpatient 2 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day,Year 27. Manner of Death After Certification: 1 Yes 2 No 1 V Natural 5 Pending To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within. and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 15, 2008 O.C.M.E. no 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001

State

Registrar

Ling Li, MD

31. Date filed (Month, Day, Year)

ORIGINAL

Assistant Medical Examiner

2008

32 Registrar's Signature

111 Penn Street, Baltimore, MD 21201

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 3:4-5PM Physician 2003 Elmer W Lewns 16 MAY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** SAINT AGNES HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex, 1 M M 2 □ F **Funeral** 02/13/1913 Months 95 Marvland 218-22-0556 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Catonsville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21228 United States 707 Maiden Choice Lane Apt 3201 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Baltimore, Maryland 21215-0036 White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) U.S. Government Chief of Office Services 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Be should be i Anna Booker Edgar P. Lewns 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 strength and the strength and strengt Walkersville, MD 21793 211 Burlington Avenue Wayne Lewns / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☑ Other (Specify) Entombment Crest Lawn Gardens 5/20/2008 Department o Important: If any injury or Marriottsville, MD 22. Name and Address of Facility
Hubbard Funeral Home, Inc.
4107 Wilkens Avenue Baltimore, 21. Signature of Funeral Service Licensee Mark T- Z 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BOWEL 24AD OI UBSTRUCTION **Physician** IMAU /Medical Due to (or as a consequence of): 24AQ OI Examiner KNEUMONIA ASPIRATION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner DAYS HROHBOSIS be executed Due to (or as a consequence of): physician a the burial-t DAYS Box 68760, PNEUNOTHORAY Physician/Medical ttending por use as as IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an autopsy perform certificate has page 2 1□ Yes 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After 1 Injury (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide To the Hospital or within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

FIMMS,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L JUBHADEN SHASHIDHARAN

31. Date filed (Month, Day, Year)

900

32. Registrar's Signature

P20808

CATON AVE DEPT OF SURGERY BALTIMORE MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Cindy Jo Leyden 1. For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 13, 2008 Year 2335 hrs dical Examiner Cindy Jo Leyden 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Dundalk 1913 Stanhope Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** reign Virginia Country) Days Hours Min. Months Director 214-80-6563 49 12/09/1958 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 X No s 23a or 28a-f show e notified at once. Maryland Baltimore Dunda1k 28a-f show Director 10g. Citizen of What Country 10e. Street and Number 10f, Zip Code 1913 Stanhope Road 21222 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes Yes, Give Yea Yes 2 X No specify: White within 72 hours after Divorced Widowed 4 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Recycling 1 21215 d be filed w 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John S. Barret, Jr. Margaret H. Habourn Be market 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 should and John S. Barret, III / Brother 2743 Belk Rd., Conway, SC 29526 item 27 lg r traumat 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, May 16, 2008 crematory or other place) Burial 2 X Cremation 3 Removal from State 5 Department o Resthaven Crematory Frederick, Maryland Donation 5 Other Specify: 21. Signature Juneral Servic Jicenses Restnaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD Approximate Interval 23a. Part I. Enter the die e, or of implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Cocaine use complicating dilated cardiomyopathy Immediate Cyse (Final disease or condition resulting in dwth) **≢**Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last XUNPENDED #23a,27,perME,g879 5/23/08 TI The law requires that the death certificate be Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions P.O. <u>۾</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, s been s 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed' death? this certificate has ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) l or Attending Physician; after death. 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Inpatient Nursing Home 5 Residence 6 ✔ Other: Scene DOA 2 ER/Outpatient 3 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural 1 Yes 2 No Pending the Director: Accident in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) To the Funeral Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ! Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie May 14, 2008 O.C.M.E. ne 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD. Assistant Medical Examiner Day 32. Registrar's Signature 2008 State Registra

			Pleas	se Type or Prin									
		1	For State Registrar	State of Ma			tment of H <i>ificate of L</i>		Mental Hy	giene Reg. No.	2008	3 1615	meaning or
42			Decedent's Name (First, Middle,	e, Last)					2. Date of De Month	eath Day	Year	3. Time of Death	
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	Examin	100	4a. Facility Name (If not institution, FutureCare C		or		4b. City, Town, or Baltin		ath	4c.	County of Dea	ath	
	Funeral				(In yrs. last bir	thday)	If Under 1 Year	If Under 24 H		rth	9. Bii	rthplace (State or Foreig	n
3	Director	6	214-22-4837 Usual Residence of Decedent	1 □ M 2 🖾 F	81	Yrs.	Months Days	Hours Mi	Sept1	4,19	26 Pe	nnsylvani	a
	land ow it		10a. State 10b. County		10c. City, Town	n or Loca	ation					10d. Inside City Limits	
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	r dea tems er m	Funeral	11. Marital Status	12. Was Decedent B Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Am Black, Whi		
36	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show ther the Medical Examiner must be notified at	2	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	NO	1	□Yes 21XNo	Specify:			Specify:Wh	ite	
Ö	2 hou	ted	15. Decedent	nt's Education	16a.		ent's Usual Occup		vorking	16b. Ki	ind of Business	s/Industry	
215	ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	`life. D	o not use retired e Maken	d) -		05	n Hom	Α.	
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anc	d be fi ental F ked ot c evel	To Be	Merle Mill	,				Laur	a				
2	shoul ind M	F	19a. Informant's Name/Relations	ship (Type. Print)	196	o. Mailing	Address (Street	and Number or	Rural Route Num	ber, City o	r Town, State,	, Zip Code)	
Š	alth a alth a 27 is		Joseph Linder	man (son) 2	19	East Ma	ain St		reed	om, P	a. 17349	_
ore	es 1 and of He filter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 ☐ Removal from State	20b. Place o	f Dispos ery, crem	ition (Name of atory or other place	ce)	Date		ocation - City o		1
Ē	Pag ment ant: i		4 □ Donation 5 □ Other (S	Specify)	Oak L	awn	Cemete	ery 5/	19/2008	Bal	timor	e,Marylan al Home,P	D
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if them 27 is marked other than "naturat", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	20don	/	12	01 Dunc	dalk A	ve. Bal	timo		d. 21222	
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that caused t only one cause on each li	the death. Do	not ente	r the mode of dyin	ng, such as card	diac or respiratory	arrest,		Approximate Interval Between Onset and Death	
E.	Physician		Immediate Cause (Final disease or condition	at	Lerosa	ler	other H	eart	Disease			Onset and Death	
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Box	death certificate t e attending physic d for use as the b	an/N	IF FEMALE: 23b. Was decedent pregnant		2 Fetal deat		Ectopic pregnanc	у		7	23d. Date of d Month	delivery Day Year	
П	the dea y the at ached fo	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ X No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death	5 🗆	Other (specify) _						
Δ.	that the		Part II. Other significant conditi	ions contributing to death t	out not resulting	in the ur	iderlying cause giv	ven in Part I.	23e. Die	l tobacco	use contribute	e to the cause of death?	
ds,	w requires that the deben signed by the should be detached	d by	Renal Lai	0					_ 1[Yes 2	!□ No 3□	Probably 4. Unknow	νn
or Vital Records,	The law requires that tte has been signed b age 2 should be deta	Completed	advance	Dementi softeel repair	7				24a. Wa	topsy	prior t	autopsy findings availat to completion of cause o	
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or/	ys dir	2	1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpati	ent 2 ER/O	utpatien Time of	t 3 DOA	4 LA Nursir	g Home 5 Re			(pecify)	_
	fing Afte fune	ion	27. Manner of Death 1 □ Natural 5 □ Pendir	Aldereth Di		Injury	Wo	ork?]Yes 2∐No	200. 2000112	0 11011 11190	,,, 0000		
Division	Attending r death. ector: Afte by the fune	Certification:	3 Suicide 6 Could	not be 28e. Place of in	jury - At home, f	farm, str	eet, factory, office	-	28f. Location	(Street a	nd Number or	Rural Route Number,	_
	al or after	eri	4 ☐ Homicide Gelenn	building, e	tc. (Specify)				Oily or 1	own, otal	ψ) 		
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	edical C	(Check only 2 Medical	ing Physician: To the best	of examination a	ge, death and/or in	n occurred at the t vestigation, in my	time, date and p opinion, death	lace, and due to to	ne cause(ie, date ai	s) and manner nd place, and (r as stated. due to the cause(s)	
	To the H within 24 To the F complete	Medi	29b. Signature and title of continu	and manner s	tated.			se number				onth, Day, Year)	
	Wit So	-	all all	~- 12			DO1:			1	7 16,		
			30. Name and address of person	n who completed cause of	death (Item 23a)) (Type,	-	-		, ,	,		
		100											

State Registrar

Dr. Melito M. Torres, M.D. 441 South Ellwood Ave. Baltimore, Md. 21224

31. Date filed (Month, Day, Year)
MAY 1 7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend Item 10e per fb 2879 5-19-08 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🚄 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** /Medical 4c. County of Death Facility Name (If not institu ion, give street and number) 4b. City. Town, or Location of Death **Examiner** 10 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 6. Sex 7. Age n yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 □ Months Usual Residence of Decedent Director death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? Court reet and Number 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♠ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any lighty or other traumatic event, Ins Menconce. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ONWal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cody 1787 19a. Informant's Name/Relationship (Type. Print) 20a. Method of Disposition Burial 2 Cremation 3 R 3 Removal from State 21. Signature of Funeral Service Licensee Approximate Interval Between 23a. Part 1. Er er the disease, or complications that caused the death. Do not enter the mode of dishock, er heart failure. List only one cause on each line. such as cardiac or respiratory arrest Onset and Death Immediate se (Final METASTANC toenoctacinom **Physician** SMONEN disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a d be detached fu P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed this certificate 1 ☐ Yes 2 🗖 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 2 ER/Outpatient 3 DOA ဥ 1 Inpatient within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05/14/2008 T amas NO ICC 2115) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 291 STOWER GALVIN EN NO treme westminster many ma 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

08-03	604
Tony	Miles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ony Miles		State of Maryland / Department of Health and Mental F-For State Certificate of Death	lygiene Reg.	No. 200	08 6 5
Physicia	n/	Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year	3. Time of Death 0552 hrs
Medical Examin ~ே		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat	May 11, 200	4c. County of Deat	
u.,		St. Joseph Medical Center Towson		Baltimore Co	-
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr Months Days Hours Mi		(MM/DD/YYYY) 9. Bi Fore	ign A 2 3
Director		21650.0238 124 2 F 54 Yrs. 1	629-	1948 °	ountry) MD
aus		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
≹ .1	_	MN Hunt-Valley			1 Yes 2 No
darylar 28a-f	당	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Co	untry?
ith the Maryland 23a or 28a-f sho notified at once.	٥	400 Symphony Circle 21030		USA	
ath wit tems 2 st be n	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,
ter des		Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: B	lack
ours af atural	함	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re	f work done	16b. Kind of Business	/Industry
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215 215 be file ntal Hy rked o	Be		inia		∞
O = = 1	₽.	15. Informa Jame/Relationship (Type, Print) 19b. Mailing Address (Street and Number 19b. Mailing Address) (Street and Number 19b. Mailing Address)	Rural Route Numb	er, City or Town, Sta	te, Zip Cade) JF Walley,
ore, MD s: 1 and 2 sho of Health and If item 27 is rer fraumati	-	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City	
ages 1 nt of H t: If i		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	15/2008	QUINAS	41/15, MD
Baltimore, permit. Pages I an Department of Hec Important: If ite injury or other tr	ŀ	Definition of Journal opening	eve tu	wered S	services
ii ii ge		16 1 4005 Unit	ich Ba	el biMz	Approximate Interval
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Examiner	Ì	Immediate Cause (Final disease or condition resulting in death) a Hypertenive atherosclerotic cardiovascular of Due to (or as a consequence of):	disease		1
		Sequentially list conditions, b			
	ji	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause c.			
sit sd	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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cords, P.O. Box 6876. In requires that the death certificate has been signed by the attending phy 2 should be detached for use as the 1.	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)			
O. In the rat the ed by the etacher	by Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?
S, P			24a. Was a		autopsy findings available
ord aw req	plet		autops perform	y prior t	o completion of cause of
Rec The I ficate I	Completed	and Death (Obs.)	1 ✓ Yes 2		Yes 2 No
/ital sicians is certifirector	o Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other; 4 Num		Residence 6 Ot	her:
of V ng Phy After th	\vdash	27. Manner of Death 28a. Date of Injury (Modelth Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred	
ion ttendir leath. for: A	aţio	1 X Natural 5 Pending 1 Yes 2 No 2 Accident			
Division of Vital Records, P.O. rat or Attending Physician: The law requires that th its after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S or Town, St		Rural Route Number, City
Pospita Phours uneral		4 Homicide 29a, Certifier A Court Black Table back of pulse states and state and place as	and due to the cause	e(s) and manner as s	tated.
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Medical	(Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred and prace, a property one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	d at the time, date a	and place, and due to	the cause(s)
A) FIFS	ğ	29b. Signature and title of certifier 29c. License number		29d. Date signed (I	Month, Day, Year)
		Que & O.C.M.E.		May 12, 2008	
		 Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212 	201		
St	ate	31. Date filed (Month, Day, Year) 33. Registrar's Signature			
Regist		MAY 1 9 2008 Seeme D. Agree			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Militch **Physician** Peter 2008 May 7:00 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Laurel 3523 Rippling Way 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1**∏** M 2□ F Australia June 11. 1955 214-98-9759 52 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Examiner must be notified at 1 ☐ Yes 2 No Director MD 28a-f Anne Arundel Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a United States 20724 3523 Rippling Way filed within 72 hours after death Hygiene. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 K No Specify. Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Engineer Aerospace 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Klutz Nik Militch ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3523 Rippling Way Laurel, Maryland 20724 Donna Militch / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Arundel Crematory | 05-17-2008 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) W. 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A up of Funeral Service 1411 Annapolis Road Odenton, Maryland 21113 ♠M01522 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 11 Str16 LUNTER Due to (or as a consequence of) **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending | for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 2 Fetal death Month 5 ☐ Other (specify) signed by the at d be detached for I ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 □Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA 1 Inpatient ၉ this 28b. Time of 28c. Injury at Work? 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death Medical Certification: (Month, Day Year) 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3∏ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Vithin 24 hours are To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortifier 29c. License number D 40854

17

Registrar

State 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

donates

ORIGINAL

227

St. Paul PL

21202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month 5 **Physician** 4:00 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Montgomery Takoma If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** Min. 1 ☐ M 2 💢 F Months Days Hours 81 Director 579-30-2145 08/26/1926 Washington, DC Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 TYes 2 No MD \mathbf{PG} Director Camp Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6357 Maxwell Drive 20746 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. þ Specify: Black 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If them 27 is marked other thar any injury or other traumatic event, the Monee. Nurse Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cleveland Hunter Mary Bell ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia D. Carter - Daughter 6357 Maxwell Drive; Camp Springs, Maryland 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/15/2008 Resumection Cemetery Clinton, Maryland 22. Name and Address of Facility Freeman Funeral Services 21. Sign ture f Funeral Service Licensee Renar endiquix 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🔲 Yes 2□ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform this certificate 2 ☐ No Yes ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient မ 1 TYes 2 ER/Outpatient 3 DOA 27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MAY 1 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14

2. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For Stete Registrar	State of Ma	aryland /		rtment of He tificate of D			giene/ [] Reg. No.	-	10100
			Decedent's Name (First, Middle, L.)	ast)					2. Date of De	ath Day	Year	3. Time of Death
	Physicia	an	James			790	Murra	4	May		2008	4:15AM
1	/Medic Examin		4a. Fecility Neme (If not institution, g	ive street and number)			4b. City, Town, of	Location of Death		1	nty of Death	
	LXumm	•	Genesis Healthc	are			Frederic				lerick	
	Funeral			Sex 7. Ag	ge (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	Count	
	Director		176-32-4999	I/AM ZUF	91	Yrs.			10/18/	1916	Penns	sylvania
	and w	-	Usual Residence of Decedent 10a, State 10b, County		10c. City, To	own or Lo	cation				10	d. Inside City Limits
	Aaryli Feho	ŏ	MD Montgo	mery	Gaith	ersb	urg					1 ☐ Yes 2 No
	28a-	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Coun	try?
	death with the Maryland ims 23e or 28e-f ehow	۵	18809 Lindenhous	e Road			20879			USA		
	death ms 2:	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No)- 14. F	Race - America Black, White,	
0	or Item	F.	1 Never Married 2 Married				1 □ Yes 2 No	Specify:	, , , , , , , , , , , , , , , , , , , ,			ite
8	ral', c	d by	3 ⊠Widowed 4 □ Divorced	Year or Dates:	WWII		/ -			105 Kind of	4 Puninggalas	ducte
2	72 h	Completed	15. Decedent's (Specify only highest)	Education grade completed)	1	6a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	king	160. King o	f Business/Inc	dustry
2	Athin ne.	ig m	Elementary/Secondary (0-12)	College (1-4or	5+)	Nav	al Office	ér		Mili	tary	
N	tygie tygie ther t		17. Father's Name (First, Middle, La	4 (st)				18. Mother's Nam	e (First, Middle	, Maiden Suπ	name)	
Maryland 21215-0036	ould be filed within 72 hours after Mental Hygiene. arked other than "natural", or Ite atic event, the Medical Exertina	Be C	Harry Eugene Mc	Murray				Agnes B	lack			
2	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other than 'natural', or liems 23e or 28e-f show aumatic event, the Medical Exarting must be notified at	2	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Number or Rui	ral Route Numb	er, City or To	wn, State, Zip	Code)
<u>8</u>	and 2 sealth ar		James MacMurray	Jr./son		18805	Lindenho	ouse Road	; Gaith			
ā,	f Heal f Heal item othe		20a. Method of Disposition		cem	e of Dispo	osition (Name of matory or other place	ce)	Date	20c. Location	on - City or To	wn, State
Ë	Pages nent of int: If it		1 Burial 2 Cremation 3 14 Seponation 5 Other (Spe		້ ບຣບາ	HS		5/13	/2008	Bathes		
Baltimore,	permit. Pages 1 and 2 should I Department of Health and Men Important: If Item 27 is marke eny injury or other traumatic.		21. Signature of Funeral Service Li	Carsee	MO0382	2 2:	2. Name and Address	ss of Facility		Campana a	933 Gi	st Ave.
m	80 E 9		Stiple H Lot	wan		R	app Funer	al & Cre	mation	Sers.	Sliver	Spring, MD
			23a. Part1. En er the disease, or c shock, or heart failure. List or	omplications that cause nly one cause on each	ed the death. line.							Approximate Interval Between Onset and Death
	Physician	1	Immediate Cause (Final disease or condition	AThe	rosch	ero	TIE Ca	141014	surgr	dise	250	
	/Medical		resulting in death)	Due to (or a	s a consequer	nce of):						
-4	Examiner		Sequentially list conditions,	b. Due to /or a	s a consequer	nce of):						
	sit ad	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseque	ice oi).						
	and and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a conseque	nce of):						
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687	phys the	edical		d								
	eath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			□Ectopic pregnance			23d.	. Date of deliv	
Вох	death atter	iciai	in the past 12 months?	4☐Pregnant	2 Fetal de at time of deal		Other (specify)	,			Month	Day Year
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S, P		by P	Part II. Other significant condition	is contributing to death	but not resulti	ing in the	underlying cause gr	ren in Part I.				he cause of death?
ıd	v requires been sign should be	ed	Kecurren	urina	ry	1401	Inte	CLLUNS				
of Vital Record	s t	Completed	Supra pub	c cathe	eter	, 6,	story	04	24a. Wa	opsy	4b. Were auto prior to co death?	opsy findings available empletion of cause of
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Division	i te	Certification:	4 Homicide determi	building,	etc. (Specify)		,		City or I	own, State)		
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		(Check only 2 Medical E	Physicien: To the be- exeminer: On the basis	of examination	ledge, dea	ath occurred at the t investigation, in my	ime, date and place opinion, death occ	e, and due to th urred at the tim	ne cause(s) an e, date and pla	nd manner as ace, and due	stated. to the cause(s)
	the hin 24 the F	Medical	29b. Signature and tifle of certifier	and manner	stated.		29c. Licen				igned (Month	
	To To cor	a5.	230. Signature and the or continu	Chron	all	m	D.	3518	3	May	13,	2008
			30. Name and address of person	who completed cause of	death (Item)	23a) (Type	Print)	st gth	Street	LITE	Aerie	K, MD
	S	tate	31. Date filed (Month, Day, Year)		strar's Sanatu	ire	41	M .	/			,
	Regis		N.	AY 1 7 2008	de	yen.	A Agon	Sid				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** RICHARD EVERETT NILSSON 2008 May 16. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City, Town, or Location of Death Examiner Randallstown SEASONS HOSPICE AT NORTHWEST Baltimore County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months: Days Hours Min. 1 ☑ M 2 □ F 219-90-6931 Director 1960 Maryland jan 2. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Directo Maryland N/A Baltimore death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 412 Croydon Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: <u>Ş</u> Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Veryl Evert Nilsson Frances Bennett ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Mrs. Frances B. Nilsson (Mother) 412 Croydon Road, Baltimore, Maryland 21212 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department o important: If any injury or once. = ₽ 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Green Mount Crematory 5/19/2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal of Fundal Servic Liden Le MITCHELL WIEDEFELD FUNERAL HOME, INC. Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Retardatio Mental Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b autopsy perform 2 No spitat or Attending Physician: Theory after death.

neral Director: After this certificate y filled in by the funeral director, pa 1 ☐Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) No Patient 1 | Yes 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tifle of certified 5/17/08

DHMH 17 Rev 1/2001

State Registrar 5 Mainst. Sulto 200

32 Registrar's Signature

Reistenburn, MD.2/13 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kajapaksemo

31. Date filed (M)

		For State Registrar	State o	of Marylar	-	artmer ertifica			and M	lental Hy	gien Reg. N		008	All years direction-holds	158
Physicia	an	1. Decedent's Name (First, Middle		CD.						2. Date of De Month	D	ay	Year	3. Time	
/Medic	al	JOHN ALOYSI				Ab City	Taum or	Location o	d Death	May	1		2008 of Death	6:4	5 a M
Examin	er	4a. Facility Name (If not institution Howard County	-		1		Lumbi		or Death			Howai	_		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs			r 1 Year	If Under		8. Date of Bir (Month, Da	th	r)	9. Birthp	lace (State	or Foreign
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r 28a	Director	10e. Street and Number		Па	arer	10f. Zi	p Code				10g. C	Citizen of \	What Coun	try?	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and Should be filed within 72 hours after death and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evanisment ust be rediffed at once.	by Funeral	11. Marital Status 1 □ Never Married ※※ Marri 3 □ Widowed 4 □ Divorced	Armed Formed 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 No 19 ve 10	42-	. Was Dece If Yes, spe 1 □Yes		ispanic Ori in, Mexican Specify:		ecify Yes or No Rican, etc.))~	Bla	ce - Americ ck, White, e y: Whit	tc.	
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s 1 ar of Hea item		20a. Method of Disposition		20b.	Place of Disp cemetery, cre			-\		Date			City or To	wn, State	
Page nent c	İ	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State	st Aru			; ~ ~	ау 20	08	Ode	enton	, MD		
permit. Departr Importa any Inju		21. Signature of Funeral Service I	Licensee	M01053	2	22. Name a	nd Addres	ss of Facility	y Don	aldson Laurel	Fur , MD	neral 207	Home	, P.	Α.
		23a. 1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	caused the dear	th. Do not e	nter the mo	de of dyin	g, such as	cardiac (or respiratory a	rrest,			Approxim Interval B	ate etween
Physician		Immediate Cause (Final disease or condition	а Нуроч	olemic	Shock									Onset and	d Death
/Medical Examiner		resulting in death)		(or as a consec											
	-	Sequentially list conditions,	U	red Abo		1 Aor	tic A	Aneur	ysm				- 4		*****
uted	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		coscler											
ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to	(or as a consec	quence of):										
cate be executed oblysician and the burial-transit	lical		d												
certific ding p	/Mec	IF FEMALE:	220 Hype ou	taoma of progr	0001				3				1		
To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending placompletely filled in by the funeral director, page 2 should be detached for use as t	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	tcome of pregn birth 2 Peta nant at time of nown	al death 3	□ Ectopic □ Other (s		<i>y</i>					ite of delive onth	ry Day	Year
s that pned to e deta	by P	Part II. Other significant conditio	=		-		-	en in Part I.		23e. Did	tobacco	use conf	tribute to th	e cause o	f death?
equire een sig	ed k	Chronic Leukemi	.a, Corona	ary Art	ery Di	sease	<i>I</i>			1 🗆	Yes 2	2 □ No	3☐ Prob	ably 4 [2	∱Unknown
The law rate has be	Completed	Chronic Kidney	Failure,	Polycy	stic K	idney				24a. Was auto perfo	psy ormed?		Were autop prior to cor death? 1 ∐Yes	osy finding npletion of 2 🖾 No	s available cause of
Iclan; Sertific Sctor,	Be (25. Was case referred to medical examiner?	I I a a sit a la	····			Tail		of Death	(Check only					
Phys	<u>۱</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death		Inpatient 2	ER/Outpatie			4 L Nu		me 5 Resi				<i>'</i>)	··
ding th. Afte	Certification: To	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig		of Injury th, Day, Year)	Injury	м	28c. Injun Work 1 □ '	yaï (? Yes 2 □1		200. Describe	HOW HIJ	ury occur	ieu		
Atter er dear ector by the	ifica	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be 28e. Place	of Injury - At h	ome, farm, s	treet, factor	y, office			28f. Location (Street	and Numb	per or Rura	Route Nu	mber,
tal or rs afte al Dir ed in	Cert	4 D Nomicide	Dulla	ing, etc.*(<i>Speci</i>	(y)				ļ	City or To	wn, Sta	te)			
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	29a. Certifier 1\(\sum_{\chi}\) Certifying (Check only one) 2 \(\sum_{\chi}\) Medical E	g Physician: To the Examiner: On the b and man	e best of my kno easis of examina ner stated.	owledge, dea ation and/or	nvestigation	at the tin	ne, date an pinion, dea	nd place, th occur	and due to the red at the time,	cause date a	(s) and m nd place,	anner as si and due to	tated. the cause	e(s)
Tot with com	Σ	29b. Signature and title of certifier	dren	A.	The	29	D217				29d. D	ate signe	d (Month, I	Day, Year)	
2X,		30. Name and address of person was Mohammed R. Ghe	who completed cause ba, 2717	se of death (Iter Hammond	m 23a)(Type 1s Fer	Print) ry Ro	ad, I	Baltir	more	, MD 21	.227	t			
Stat Registra		31. Date filed (Month, Day, Year)		gistrar's Signa		boule	,								
			7												

08-03496
Robert Petty

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert Petty	1- Fo Regis	r State	State	of Maryland /		ment of ficate of		d Menta		Reg. N	o. 705	0 1515
Physician/ Medical Examine	1. D	ocedent's Name (First, MOBERT LYVA)		PETTY					2. Date of D Month May 7, 2	Day 2008		3. Time of Death 1440 hrs
,		acility Name (if not instited) 308 Hilltop Court	ution, give	street and number)		4	Laurel	r Location of			4c. County of Death Prince George	e's
Funeral Director		37-02-8429	6. Sex	7. Age	(In yrs. last	birthday) Yrs	If Under 1 Ye Months Da		Min.		M/DD/YYYY) 9. Bir Foreig 1957	thplace (State or gn puntry) NC
and show any nce. Or	10a.	Residence of Decedent State 10b. Cour Prin	nty	eorge's	10c. City, To	own or Locati	on					10d. Inside City Limits 1 Yes 2 No
the Maryland a or 28a-f sh tiffed at onc.	10e.	Street and Number	Cour	t			10f. Zip Code	3		_	Citizen of What Cou	ntry?
er death with , or items 23 r. must be no		Marital Status Never Married 2 X Y Widowed 4	-	12. Was Decedent Armed Forces? 1 XXYes 2 If Yes, Give Yeal 97	No	If Y		n, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No-	White, etc.	rican Indian, Black,
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	·	. Decedent's Education (Specify on	ly highest grade com College (1-4 or 5	pleted) 1	6a. Deceder during m	nt's Usual Occup lost of working lif	ation (Give k e. DO NOT (ind of work done use retired)		b. Kind of Business	/Industry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		Father's Name (First, Mic	Idle, Last)	1 year			uter I.	18.Mother's	s Name (First, Midd	le, Maid	ien Surname) 11	Internationa
more, MD 21: Pages 1 and 2 should then of Health and Men nnt: If iten 27 is mar nr other traumatic eve	19a E	Informant's Name/Relat Lizabeth B. Method of Disposition				9308		Cour		. , M	, City or Town, Stat aryland Oc. Location - City o	20708
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If iten 27 is in injury or other traumatic	1 [Burial 2 Crema Donation 5 Othe Signature of Funeral Ser	r Specify:		ate cre	ematory or ot gett G	her place) rove Cer	netery	5/13/200 ral Home,		Forest Ci	ty, NC
Physician		Part I. Enter the disease failure. List only one ca	e, or comp	lications that caused	M0077(the death. [0 i 3	13 Talbo	ott Av	enue Lau	ırel	, Marylar	Approximate Interval Between Onset and
/Medical Examiner		nediate Cause (Final disecondition resulting in deat	asa a.				rotic car	liovascu	ular diseas	9		Death
nsit Framiner		quentially list conditions, ny, leading to immediate se. Enter Underlying Ca sease or injury that initiat ents resulting in death) L	use ed c ast	Due to (or as a cons								
0, be execu- sician and burial - tra	X	UNPENDED	d.	#250,FII, 2			/21/08 TT				23d. Date of delive	
Vital Records, P.O. Box 6876(ysician: The law requires that the death certificate this certificate has been signed by the attending phy director, page 2 should be detached for use as the b. De Completed by Drussician/Ma	23b.	Was decedent pregnant past 12 months? Yes 2 No 9	in the		time of dea		etal death (B Ectopie	c pregnancy	-	Month	Day Year
	<u>\$</u>	t II. Other significant co Diabetes m			h but not res	sulting in the	underlying caus	e given in Pa	1	Yes	2 No 3 Pr	to the cause of death? obably 4 Unknown autopsy findings available
of Vital Records, ing Physician: The law required After this certificate has been significant and trector, page 2 should be reserved.	No.								1	Vas an outopsy performe 'es 2	prior to ed? death?	completion of cause of
Vital F ysician: his certifi director,	25. D	Was case referred to me examiner? 1 ✓ Yes 2 No		Hospital: 1 Inpati	ent 2 1	ER/Outpatier		Other	(Check only one) Nursing Home 5	Re	esidence 6 🗸 Oth	ner: Scene
Division of Vital Records, P.O. ra afterding Physician: The law requires that the safe death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	27	Manner of Death X Natural 5	Pending Investigati	28a. Date of Inj (Month, Day,	rear)	28b. Time of	1	jury at Work	No		w injury occurred	Cit.
hou by		Suicide 6 Homicide	Could not determine	be 28e. Place of I			eet, factory, offic		or To	wn, Stat	e)	Rural Route Number, City
ithin 24	One one	2 Medical	Examine	r: On the best of n r: On the basis of exa and manner stated	mination an	nd/or investig	ation, in my opin	ion, death o	courred at the time,	date an	d place, and due to	the cause(s)
		Signature and title of or Signature and title of or	Din	I IMID.			1	ense number C.M.E.			May 8, 2008	ontn, Day, Year)
\emptyset	30.	Name and address of pe Donna M. Vincent		completed cause of Assistant Medi			1 Penn Stre	et, Baltim	ore, MD 21201			
Stat Registra		Date filed (Month, Day,)		32. degistr	ar's Signatur	re	Also.					
DHMH 17 Rev 1/200	1			00145	A SPAN	ORIGIN	AL					

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State of Maryland / Department of Health and Mental Hygiene

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Distance.	1000	3.7	100	- 6	100		1	,,,,,,

		I- For State Registrar		Cei	rtificate	of I	Death	7			F	Reg. N	o		
Physicia		Decedent's Name (First, Middle)	e,Last)							2.	Date of De	ath Day	/ Year		3. Time of Death
Ŋedical Examir		Robert Michael	Perelli								Month April 30,	2008	, rear		0905 hrs
		4a. Facility Name (if not institution 2929 Bachman Road	on, give street and n	umber)		- 1	. City, To Manch	own, or Lo nester	ocation of	Death			4c. County o Carroll	Death	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday	()	If Unde	r 1 Year	If Under	24Hrs.	8. Date of E	irth(M	M/DD/YYYY)	9. Birth	place (State or
Director	İ	215-80-7850	<u>1√</u> M 2 F		46	Yrs.	Months	Days	Hours	Min.	Nov.	4,	1961	Foreign Cou	ntry)Maryland
	F	Usual Residence of Decedent		Idon City	, Town or Lo	- ontio									10d. Inside City Limits
w any		10a. State 10b. County	7.7	Toc. City											1 XXYes 2 No
daryland 28a-f show 1 at once.	후	Maryland Carr	011		Manch		ter 10f. Zip	Codo				10o C	itizen of Wh		
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be notified at once	Director	10e. Street and Number 2929 Bachman R	oad. P O	Box 789	R	l		1102					itizen of Wh		es
ith th		11. Marital Status		cedent Ever in U		Was				n? (Spec	cify Yes or N		Ameri 14. Race		an Indian, Black,
r death w	Funeral	1 Never Married 2XX M									ican, etc.)		White	, etc.	
ifter de		3 Widowed 4 Div	orced If Yes, Give Ye		1		Yes 2	X No	specify:				Specify:	Whi	te
ours a atura	ğ þ	15. Decedent's Education (Spe	cify only highest gra	de completed)	16a. Dece			Occupatio				16t	. Kind of Bus	siness/In	ndustry
OI 3	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)]	-		Driv		200 1011101	u)		Tran	anor	ctation
within siene.	E	12th 17. Father's Name (First, Middle	Leet\		<u> </u>	TT	uck			Name (First Middle	Maid	en Surname)	_	
- E - O .	Be C	Michele Perell						"			ose Be		,		
212' uld be Mental marke		19a. Informant's Name/Relations	ship (Type, Print)		19b. Ma	ailing .	Address	(Street	and Numi	ber or Ru	ral Route N	umber,	City or Town	n, State,	Zip Code)
MD d 2 shoulth and n 27 is aumatic	7	Kathy A. Perel	li (Wife)		207	Ea	st W	alnu	t St	reet	, Apt.	Α,	, Hano	ver,	PA 17331
	Ī	20a. Method of Disposition 1 XXBurial 2 Cremation	a 2 Demoved		Place of Dis				etery,	Mar	Date y 3,	20	c. Location -	City or 7	Town, State
MOF Pages nent of ant: If		4 Donation 5 Other S			rraine	2 P	ark	Ceme:	tery	200	-	V	voodla	wn,	Maryland
Baltimore, permit. Pages I a Department of He Important: If ite	1	21. Signatur of Fund al Service			i	22. Na F.C.k	me and	Address of	of Facility	l Ch	apel,	P. /	Α.		
	Ÿ	236 Part I. Enter the disease, or	<u>)</u>		10	329	6 Ch	armi	1 Dr	ive,	Manch	ıesi	ter, M	<u>aryl</u>	and 21102 Approximate Interval
Physician (Medical	1	fallure. List only one cause	on each line	Complica								irest, s	STIOCK, OF THE		Between Onset and Death
xaminer	4	Immediate Cause (Final disease or condition resulting in death)	e a	a consequence of			OILL	OHIC		JIIOI		_			
		Sequentially list conditions,	b		,-										
	iner	if any, leading to immediate		a consequence of	of):										
, ti	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	of):										
1760, ficate be executed g physician and the burial - transit			d	Item 23	la 27	Dei	r me	o879	9 05	/20/d	18dhh				
O, e be es sician burial	Physician/Medical	UNPENDED				PC	L UK.	,go/.		207		-	22d Date of	dolivon	
8760, ifficate be ng physici as the buri		IF FEMALE: 23b. Was decedent pregnant in t		, outcome of pres birth		Feta	al death	3	Ectopic	pregnan	су		23d. Date of Month		Day Year
Box 68' e death certificate attending ed for use as	sicia	past 12 months?	4 Preg	nant at time of d		_	er (Spec								
that the death certined by the attending detached for use as	چُ	Part II. Other significant condit	9 Oliki	nown	roculting in	tho ur	aderlying	cauca di	uan in Pa	rt I	Z3e Dic	Ltobac	co use contr	bute to	the cause of death?
P.O.	by	rait ii. Other significant condi-	tions contributing	to death but not	resulting in	uie ui	idenying	cause gr	vennita						ably 4 🗸 Unknown
ords, P w requires t us been sign should be o	Completed										24a. Wa	as an			topsy findings available
COF law re has b	ng M										pe	opsy formed	d? c	death?	completion of cause of
tal Rec tian: The l certificate b		25. Was case referred to medica	SI					26.Place	of Death	Check of	1 Yes	8 2	No 1	✓ Ye	s 2 No
on of Vital Records, P.O. Box 68 ending Physician: The law requires that the death certi ath. or: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use as	o Be	examiner? 1 ✓ Yes 2 No	Hospital:	Inpatient 2	ER/Outpa	atient			Other 4		Home 5	Res	sidence 6	Other	: Scene
of \\ ing Phy After th	-1	27. Manner of Death	28a. Dat	e of Injury	28b. Time	e of In	jury 2	28c. Injury	at Work	? 2	28d. Describ	e how	injury occurr	ed	
ion of tending Pheath.	힐		ding	th, Day,Year)				1 Y	es 2	No					
S A P S S	Certification:	3 Suicide 6 Cou	id not be	ce of Injury - At I	nome, farm,	stree	t, factory	, office bu	ilding, et	c. 2	28f. Location or Town			er or Ru	ral Route Number, City
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		29a. Certifier	Physician: To the be	·	doe. death o	occurr	ed at the	time, dat	e and pla	ice, and c	due to the ca	use(s)	and manner	r as state	ed.
To the Hos within 24 h To the Fun	Medical	(Check only one) 2 Medical Exa	aminer: On the basis	of examination	and/or inves	stigati	on, in my	opinion,	death oc	curred at	the time, da	te and	place, and o	Jue to the	e cause(s)
F 3 F 8	S.	29b. Signature and title of certific		otatos.	_		290	. License	number			29	9d. Date sign	ed (Mor	nth, Day, Year)
		Potr la	Hot	lor ~	2			O.C.N	1.E.			V	/lay 1, 200	18	
3	t	30. Name and address of person		,			444 -			141	ND 041	\\\			
		Patricia Aronica-Polla		tant Medical Registrar's Signa		er	111 P	enn Str	eet, Ba	itimore	e, MD 212	201			
St Regist	ate rar	31. Date filed (Wooth, Day, Year)	2008	ese M	Res	a Al									
DHMH 17 Rev 1/20	001		OCME		ORIG	INAL									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #21 Per FH G879 5/22/08 certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Paul trank 05 16:37 15 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Medica Center Baltimore if Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 MM 2 □ F 62 Director 214-54-3850 11/19/1945 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director MD Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r 20657 USA 13034 Barreda Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 2 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status ı "natural", or Item: ledical Examiner n Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White 1966-1968 Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Construction r than " Elementary/Secondary (0-12) College (1-4or 5+) Equipment Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Is Important: If item 27 Is marked ot any injury or other traumatic ever once. Hattie A. Carl E. Paul ပ Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan A. Moxley/Sister 2518 Fairway Dr. Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition May 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Beltsville, Maryland 4 Donation 5 Dother (Specify) Inc. 2008 Chesapeake Cremator fer 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Tuneral Alternatives Linda Sue Ritter M01443 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 days Physician disease or condition resulting in death) rneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If ves. outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 ☐ Unknown been signed the should be detailed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 4 Unknown 1 TYes 2 No 3 Probably ecrosis, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 (Inpatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Certification: 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 □ Yes 2 □ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Fural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Morth, Day, Year) T/owers

DHMH 17 Rev 1/2001

State

Registrar

ADRIENNE

31. Date filed (Month, Day, Year) MAY 1 7

3+1

Street

Greene

Baltimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

LEWERS,

10

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Physician ETAWAY /Medical 4a. Facility Name (If not institution, give street and number) Examiner SALTIMORE Park Kehas KOLAND If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5601. 28, 1917 **Funeral** Months Days 1 ☐ M 2 💢 F Director with the Maryland 10c. City, Town or Location 10b. County ns 23a or 28a-f show must be notified at BACTIMORE Completed by Funeral Director 10e. Street and Number r than "natural", or items 23a the Medical Examiner must b Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23s . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No 3altimore, Maryland 21215-0036 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) NOMESTIC 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains daub HIEK alenwood 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XBurial 2 ☐ Cremation 20/08 4 Donation 5 Dother (Specify) 22. Name and Address of Facility BEVISEN D. CROWNETSE FLS 21. Signature of Funeral Service Licenses 10 martie Edmondson Ave-BACTO. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a construence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consectionce of) Physician/Medical Examiner for use as the burial-tran Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

210 BUYNESS

2008 2:10AM Birthplace (State or Foreign Country) 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? U. 5.A Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry RIVATE , Md. 21239 BALTO., md. 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 05-16-2008 REISTERSTOWN, MD

State Registrar D0059107

CENTER DRIVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month Year Physician 1:45 A.M 05 08 06 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner GOOD SAMMRITAN BALTIMORE HOSP17 AL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (Jay) 5. Social Security Number 6. Sex rs last birthday) 9. Birthplace (State or Foreign **Funeral** Days 217-22-329 Usual Residence of Decedent 1 □ M Director 10d, Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County la or 28a-f show t be notified at Yes 2 No Director timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21212 USA Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes Specify: þ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or c once. Marial 2 ☐ Cremation 3 ☐ Removal from State 115/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of the shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPTIC SEPSIS **Physician** SHOCK disease or condition resulting in death) WITH /Medical Due to (or as a consequence of): Examiner ISCHEMIC COLITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner · AWIE FAILURE RENAL Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by DEMENTIF 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed) 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1, Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To Division or 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours af

To the Funeral D

completely filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) RES ODO 08 Sharma Deep address of person who completed cause of death (Item 23a) (Type, Print) Sharma Samaritan Hespital 31. Date filed (Month Registrar's Signature State Registrar

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LLORAN CH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perINF. G883, 9/18/08, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year \mathbf{A}^{M} 2:20 2008 Max P. Rothen May 17, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs. Holy Cross Hospital Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Months 1 X M 2 □ F Director 267-52-5181 81 1926 Switzerland June 18. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 ☐ No Directo Maryland Montgomery Chevy Chase 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 8503 Freyman Drive 20815 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💹 No Specify: White 3K Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Butler 12 Private Homes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elsa Meyer Max Louis Rothen ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatriz Villariom (Step-Daughter) 8503 Freyman Dr., Chevy Chase, MD 20815 permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria! 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 5/18/08 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Panciera Family Funeral Care 21. Sign were of Funeral Service License 4200 Hollywood Blvd., Hollywood, FL mun 33021 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Years disease or condition resulting in death) a Alzheimer's Dementia /Medical Due to (or as a consequence of): **Examiner** Days Terminal Delirium Sequentially list conditions, if y hearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Days Acute Renal Failure Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as 1 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Prostate Cancer 2€ No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Anemia page 2 s autopsy 1 Yes 2 € funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Dopatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation 1 Tyes within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

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31. Date filed (Month, Day, Year) MAY 1 9 2008



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Suparuch.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D 0065485

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM/I De per FH (879 5/19/18 WS)
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 3.25AM 16 2008 RUSTIN MA LUNDRE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Balto N/A Long Green N/H Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 ₩ F Yrs 225-98-0350 42 4-2-1966 Director VA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. Count 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director MD N/A Balto 10e. Street and Number Street 10g. Citizen of What Country? 10f. Zip Code 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 10th grade Disabled 7 is marked other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Leonard Rustin Pages 1 and 2 should I Joyce Stewart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linnette Hines-Daughter 2806 Ganley Drive Balto, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenmount Cem Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-19-2008 Baltimore, MD March F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility East la M Way 1101 E. North Avenue Balto, MD 21202 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): Examiner STAGE AIDS month END Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit requires that the death certificate be executed RENAL FAILURE month Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending properties as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown s been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 s page certificate 21 No 1☐ Yes or Attending Physician: After this certification funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Injury Natural 5 Pending hours after death.

uneral Director: Af
ely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Spuple 00053150

Registrar

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State

9650 sanhago

21045

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Mopth, Day, Year) 2008

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2. Registrar's Signature

08-03345 Gerald D. Roberts				Ink. Ensure All Copie of Health and Mental H		ole. 20	60 16	1.0
	1- For State Registrar	•	Certificate of	of Death	Reg. N	100		
Physician/ Mc~ical Examiner	1. Decedent's Name (First, Mic				2. Date of Death Month Da May 2, 2008	y Year	3. Time of Death 0532 hrs	
(4a. Facility Name (if not institu	ition, give street and number)		4b. City, Town, or Location of Death		4c. County of Dea		

		Registrar			g. No	
Physici	an/	1. Decedent's Name (First, Middle,Last)		2. Date of Deati		3. Time of Death
ic⊲ical Exami		Gerald D. Roberts		Month May 2, 200	Day Year)8	0532 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
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any		10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
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fler of ", or		3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 X No specify:		Specify: wh:	ite
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Baltimore, permit. Pages I an Department of He Important: If ite		21. Sign are of Ronald S Wads, Director S	2. Name and Address of Facility tate Anatomy Boar	d 655 W.	Baltimore	Street
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87 tifica ng p	Ž	23b. Was decedent pregnant in the	Fetal death 3 Ectopic pregr	nancy	Month	Day Year
		4 Pregnant at time of death 5	Other (Specify)		Į.	
Box 687 he death certific the attending p	ysic	1 Yes 2 No 9 Unknown g Unknown				
Division of Vital Records, P.O. Box Hospital or Attending Physician: The law requires that the death 4 hours after death. Funeral Director: After this certificate has been signed by the atterty filled in by the funeral director, page 2 should be detached for us	Phy	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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Divisior Hospital or Attend 24 hours after death 5 Funeral Director: etely filled in by the	ŭ	29a. Certifier		1		
	ledical	check only one) 2 Medical Examiner: On the basis of examination and/or investigations.	tigation, in my opinion, death occurred	at the time, date	and place, and due to t	he cause(s)
To the J vithin 2 To the J complet	ed	and manner stated.				<u> </u>
	Σ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Me	ontn, Day, Year)
•		Yamele & auxhall MO	O.C.M.E.		May 2, 2008	
		30. Name and address of person who completed cause of death (Item 23a)				
		Pamela E. Southall, MD Assistant Medical Examiner	111 Penn Street, Baltimore,	MD 21201		
		- 2				
S Regis	tate	31. Date filed (Month, Pay, Year) 2008 32. Registrar's Signature	perte			
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Registrar DHMH 17 Rev 1/2001 OCME 2006

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min	er	4a. Facility Name (If not institution, give street and number)					own, or L SETHE	ocation of	f Death		4c. C	ounty of MO1	NTGOM	ERY
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or		090-16-6705	1 M 2 F	85	Yrs.	Months	Days	Hours	Min.	(Month, Da	1 <i>y, Year)</i> 31/19	22	Country)	,
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	Director	10e. Street and Number	JOMEL J		concou	10f. Zip 0	Code				10g. Citize	en of Wha	at Country	?
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	Be	Samuel Robbins	,				'	Tan		Saniovi [,]		umame)		
	ြ	19a. Informant's Name/Relationshi	-		19b. Maili	ng Address ((Street ar			al Route Numb		Town, St	ate, Zip Co	 ode)
		Jean Adams Robb	ins/Wife		720	3 Brad	dley	Blvd	l. Be	thesda	, MD	2081	7-	
		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	2 Damoual from 5		Place of Dispo cemetery, cre	sition (Name matory or oth	e of her place,)		ate May 14	20c. Loc	ation - Ci	ty or Town	, State
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i i		21. Signature of Funeral Service L	ic en see	M003	82 2	2. Name and	d Address Funer	of Facility	y Crema	ation S	ervice	es		
İ			man			933 Gi	ist A	ve.	Silve	<u>er Spri</u>	ng, Ma			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 6:05 PM Miranda Mar 15 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore nion Memoria 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Months Hours 1 M 2 F 219-70-7374 Usual Residence of Decedent Director death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show 1 TYes 2 THO MD Examiner must be notified Director 10g. Citizen of What Country? 10e. Street and Number Hills Mood Enchan teo items 23a 2111 Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite, any injury or other traumatic event, the Medical Examine. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ NO <u>\$</u> 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) stomer Service Mep 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6401 Loch Maven Blvd Apt 516 Baltimore, MD Helen (20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 1 Park 5.21.2008 Baltimore MD 12. Name and Address of Facility Vayon C. Greene Funeral services 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee C. Theeno Vaughn C. Steine 4405 York Ad Baltmore M

23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 14905 York Ad Baltimore, MD 21212 Approximate Interval Between Onset and Death Acute Respiratory Distress Immediate Cause (Final disease or condition resulting in death) Syndrome Physician /Medical Due to (or as a consequence of): (month Examiner Pheumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine 5months The law requires that the death certificate be executed burial-transit Immunocom promise and Due to (or as a consequence of): physician Box 68760 9 months Hodgkins Lymphoma Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 TYes 2XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was ar autopsy Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation To the nosponse within 24 hours after death.

To the Funeral Director: After the function in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) een,MD AT 2438946 May 15,2008 Villecar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Baltimore, MD Meegan C. Green, MD Union Memorial Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

Physician /Medical Examiner **Funeral** Director show Director Funeral ģ

Division of Vital Records, P.O. Box 68760 ası the signed by t icate has been sig certificate director. this funeral After t within 24 hours after death

To the Funeral Director:
completely filled in by the

Amend Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland Department of Health and Mental Hydiene

1- State Amend 28a-f, perME, g880 6/3/08 TT

Amend Item 28b per me, g880, 06/19/08dhb

Reg. No.

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) **Dorothea Wassmuth** 2. Date of Death 3. Time of Death Schmidt. Month Dorthea. May 8, 2008 2:10 Schmidt 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🗓 F 77 N/A April 27, 1931 Germany Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mydfoal Ever. For must be notified at 1X Yes 2 □ No Germany Dinslaken 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rosen Strasse 38 46535 Germany 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕅 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Midowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johann Heinrich Wassmuth ဥ Elisabeth Dilcher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Weselerstrasse 140 Dinslaken, Germany 46537 Klaus Schmidt (Son) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Surry Lane Crematory 5/17/08 4 ☐ Donation 5 ☐ Other (Specify) Petersburg, VA 22. Name and Address of Facility 21. Signature of Funeral Service License J.T. Morriss & Son Funeral Home Mun 103 S. Adams St., Petersburg, VA 23804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit attending physician and resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery in the past 12 mon 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔁 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 2 🗆 No 1 □ Yes 1 ☐ Yes 2 🗷 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 05/06/2008 2:56 p 5 Pending subject passenger in car collided w/a car investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Roadway Crain Hwy. @ VFW Rd. Waldorf, MD 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 30. Name and address of person who co em 23a) (Type, Print) 3001 Hospital Dr., Cheverly, MD 20785 Willie C. Blair, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiené $\mathbb{U} \, \mathbb{U} \, \mathbb{U}$

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			Montgomery General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. la						If Under	ney	If Under	24 Hrs.	8. Date of Bir		TOTTLE		ace (State or	Foreign
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	or 2	Director	10e. Street and Nu	mber					10f. Zip	Code				10g. Ci	itizen of V	What Count	try?	
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9500-61212	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f ehow thit the Medical Examinar must be modified at	by	3 Widowed	4 Divorced	Year	or Dates:		'	103	243 140	Specify.	,			Specify	· WIIII		
7	2 h	Completed	/Sne/		t's Education	ad)	16a	Deced	lent's Usu	al Occupa	ation during mos	et of work	ina	16b. F	(ind of Bu	usiness/Ind	ustry	
	Pin Pin	ple	Elementary/Seco			e (1-4or 5-	F)	life. E	DO NOT U	se retired	()	1 01 110/11	9					
7	d wit	no	2.0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		4	Tr	Treasurer						Bui	Lldir	ng & 1	g & Loan	
	Hygi other	a)	17. Father's Name	(First, Middle,	Last)						18. Moth	er's Name	e (First, Middle	. Maidei	n Sumam	7 0)		
a	d be ental	OB	Clarence	e H. Sc	uder						Lu	la E	stelle	Scag	ggs			
Maryland	s 1 and 2 should be (Health and Mental I Item 27 le marked o other traumatic eve	F	19a. Informant's N	ame/Relations	hip (Type, Print)		198	o. Mailin	n Address	(Street :	and Numb	er or Run	al Route Numb	er. City	or Town.	State. Zip	Code)	
<u>8</u>	nd 2 salth an 27 le				r/ Brot	hor							urel, M				,	
	of Health Item 27				I/ DIOC	IICI	20b. Place o				Cirac		Date			City or To	un State	
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Baltimore,	permit. Pages Department of I Important: If It any injury or o		21. Signature of Fu	neral Service	Licensee			22	. Name ar	d Addres	ss of Facili	ity Do	naldson	Fur	neral	L Home	e, P.A	
n	88 5 8 8		J. Ten	Shiles		M	01053	31	3 Tal	bott	Ave	. , L	aurel,	MD 2	20707	7		
			23a. P. 11. Enter t	he disease, or	complications th	at caused	the death. Do	not ente	er the mpo	e of dyin	g, such as	cardiac	or respiratory a	arrest,			Approximate Interval Betw	1000
6	, 3, D		tmmediate Cause	(Finat	only one cause		eur	7 1	0.1	•							Onset and D	
4.	Physician /Medical		disease or condition resulting in death)	on	a				- ' '	1								
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	w requires that the death certificate be executed to been signed by the attending physician and should be detached for use as the burial-transit	Medical																
ŏ	andir use	-	IF FEMALE: 23b. Was deceden	t pregnant			of pregnancy		Totosio o						23d. Da	te of delive	ry	
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o.	y the	Physician	9 Unknown		9□∪	nknown												
7	law requires that the as been signed by th 2 should be detache	4	Part II. Other signif	ficant condition	ons contributing	to death bu	t not resulting i	in the ur	nderlying o	ause give	en in Part	l.	23e. Did	tobacco	use cont	nbute to th	e cause of de	eath?
Ś	sign d be	l by											1 🗆	Yes 2	O No	3 ☐ Proba	ably 4 ⊡U	nknown
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r	The ate his page	, on											perf 1 ☐ Yes	ormed?		death? 1 🗌 Yes	2□ No	
VItal	ysician: The lav is certificate has director, page 2	a l	25. Was case refer	rred to medica							26. Plac	e of Deat	h (Check only	one)				
>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 🛱	No	Hospital:	Inpatier	nt 2 ER/O	utpatien	t 3 D	Oth	er: 4 🗆 N	ursing Ho	me 5 Res	idence	6 □Oth	er (Specify)	
Ö		. T	27. Manner of Deat		28a. D	ate of thiun	/ 28b.	Time of		8c. Injun			28d. Describe					
0	ding fun	to	1 Natural 2 Accident	5 Pendir investi	9	Month, Day	Year)	tnjury	м		k? Yes 2.⊡]No						
S	deal deal ctor: / the	ica	3 Suicide	6 Could	not be 200 B	tace of Inju	ry - At home, fa	arm str	eet factor	v office			28f. Location	(Street a	nd Numb	er or Rura	Route Numl	Der.
Division	or A of A Direction by	Certification:	4 Homicide	determ	ined b	uilding, etc	(Specify)	, 511	501, 120101	, 011100			City or To	wn, Stat	te)			,
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral		20a C-44	109 0-111	- Physician -	4b - b - ·	4 mars 1 m m m m m m			-1.05		and of a	mand of the state of				-1	
	Hos Fun ely f	edical	29a. Certifier (Check only		Examiner: On the	ne basis of	examination ar			d at the time, date and place, and due to the cause(s) and manner as stated. n, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
	the the	Med	one)	4.00- 4		nanner stat	ed.		1 00				-	201 5	ata elec	d (Adams)	Day Vacat	
	No To	2	29b. Signature and			1		1			e number			29a. Di	ate signe	d (Month, I	Jay, rear)	\circ
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	_		30. Name and addi				ath (ttem 23a)	(Туре,	Print)			**********						
	15		Ata Mota							ле, (Olney	, MD	20832					
	Sta	te	31. Date filed (Mor															
	Registi			AY 19	2008	Poplar.	r's Signature	Gol	MIL									
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DHMH 17 Rev 1/2001

08-03314

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hvoiene

uzzane Sykes	State of Maryland / Department of Ho 1-For State	
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death 3. Time of Death
ledical Examine	bullune by kes	April 30, 2008
	tar a said training to the said training to the said training trai	ity, Town, or Location of Death 4c. County of Death wancock Washington
Funeral	5. Social Security Numbeunk 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or unk
Director	1_M 2XF 52 Yrs.	onths Days Hours Min. May 27, 1955 Country)
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
A .	MD Washington Hancock	1 Yes 2 X No
ine Maryland t or 28a-f show illed at once.	10e. Street and Number	f. Zip Code 10g. Citizen of What Country? 21750 USA
- 2 -	1	cedent of Hispanic Origin? (Specify Yes or No-
r death with or items 23 or items 23 or items 24 Europe no	11. Marital Status 12. Was Decedent Eventions. 13. Was Decedent Eventions.	pecify Cuban, Mexican, Puerto Rican, etc.) White, etc.
safter daranti, or niner m	3 Widowed 4 Divorced If Yes, Give Year 1 Ye	2 X No specify: Specify: white
hours 'natur Exami		sual Occupation (Give kind of work done unk 16b. Kind of Business/Industry unk of working life. DO NOT use retired)
5-0036 led within 72 hours a led within 72 hours a ltygiene. other than "natural the Medical Examin	unk unk	
15-0036 Tiled within 7 Hygiene. d other than the M dia		unk 18.Mother's Name (First, Middle, Maiden Surname) unk
T. P 4 E 5 C	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ac	dress (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD d 2 shot lith and n 27 is numatic	O.C.M.E. 111 Per	nn Street Baltimore, MD 21201
or Heal	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or other	
altimore, mit. Pages la ppartment of He pportant: If ite jury or other tr	4 Donation 5 X Other Specify: in state	a and Address of Facility
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and I Important: If iten 27 is in injury or other traumatic	Simol/// (NOC) Ral	te Anatomy Board 655 W. Baltimore Street
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the railyre. List only one cause on each line.	ode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and
/Medical_ _xaminer	Immediate Cause (Final disease or condition resulting in death) a. Complications of cirrhosi Due to (or as a consequence of):	s of the liver Death
	Sequentially list conditions, b.	
i	if any, leading to immediate cause. Enter uncertying cause	
ed lisit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
		1/00 mm
). Box 68760, the death certificate be executly the attending physician and robed for use as the builal - man behaviorism of the control of t	AMENDED #23a,PII,27,perME,g879 5/2 IF FEMALE: 23c. If yes, outcome of pregnancy	1/08 '11' 23d. Date of delivery
687 certifica ading ph	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal 4 Pregnant at time of death 5 Other	death 3 Ectopic pregnancy Month Day Year (Specify)
Box e death c the atten	1 Yes 2 No 9 ✓ Unknown g Unknown	
P.O. E es that the d igned by the be detached		erlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown
Records, P.(The law requires that ficate has been signed , page 2 should be det	Hypertension	24a. Was an 24b. Were autopsy findings available
Cords,		autopsy prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Recysician: The his certificate director, page		26.Place of Death (Check only one)
F Vital Physician r this certi	Yes 2 No 1 Inpatient 2 Ervoutpatient 3	
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been stand in by the funeral director, page 2 should death.		y 28c. Injury at Work? 28d. Describe how injury occurred
iSiO - Atten er deatl rectors by the	2 Accident Investigation 28e. Place of Injury - At home, farm, street,	actory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Division of spiral or Attending to hours after the neral Director: After filled in by the fune of the filled in the fune of the filled in the fune of	3 Suicide 6 Could not be determined (Specify)	or Town, State)
DIVIS To the Hospital or A within 24 hours after completely filled in b		at the time, date and place, and due to the cause(s) and manner as stated. , in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the He within 24 To the Fe completed	and manner stated. 29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
	Pote : (1700 - Popor	O.C.M.E. May 1, 2008
	30. Name and address of person who completed cause of death (Item 23a)	44 Dans Street Boltimore ND 24204
01-	24 Date Start Start Day Vent 200 Periotrate Signature	11 Penn Street, Baltimore, MD 21201
Sta	MAY 1 9 2008 Server of Special States of Special Special Special States of Special S	

08-03083 Michael H Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day April 20, 2008 2239 hrs al Examiner Michael H. Smith 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Laurel Regional Hospital 9. Birthplace (State or Foreign If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number Unk6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Funeral Months Days Hours 1 M 2 F Director June 12, 1946 61 Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20901 USA 8629 Piney Branch Road 14. Race - American Indian, Black, unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Mantal Status 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married unk Yes white Yes 2 X No specify: Divorced If Yes, Give Year 3 Widowed ģ 16a. Decedent's Usual Occupation (Give kind of work dond10K | 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) unk 18.Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဂ 19a. Informant's Name/Relationship (Type, Print) 111 Penn Street Baltimore, MD O.C.M.E. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in state 3 Large and Affacts of Facility oard 655 W. Baltimore 21. Signature of Euperal Service Sicensee, Director Baltimore, MD 21201 Part I. Enter the direase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart miliure. List only one cause on each line. Approximate Interval ^ohysician Between Onset and Medical Death a. Methadone and cocaine intoxication Immediate Cause (Final disease -xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - trar sician/Medical X UNPENDED 44294,PII,27,&28a-f, perME,g879 5/22/08 TT The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Š Atherosclerotic cardiovascular disease ficate has been si page 2 should b Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of certificate has performed? death? 1 🗸 Yes ✓ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25 Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 V ER/Outpatient 3 DOA After this 1 V Yes No Director: After the 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year 27. Manner of Death Certification: Natural Division 1 Yes 2 X No 5 Pending Fnd 4/20/2008 | Fnd 10:08 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.

found on ground in empty parking lot 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be or Town, State)
Main St. Suicide within 24 hours a. To the Funeral E Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 21, 2008 O.C.M.E. IMP. m me 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD Assistant Medical Examiner

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #10d Per FH G879 5/19/08 JH Certificate of Death Red. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10:27AM SILVERMAN THELMA 19 A4 15 /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY SINAL HOSPITAL OF BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/11/1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 X F Days Hours Min. MD Director 217-12-5040 Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits 10b. County XXYes 2XHo Directo MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3317 LUDGATE ROAD 21215 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 1 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **ABRAHAM** HEYMAN REBECCA KAHN 10 19a. Informant's Name/Relationship (Type, Pript)
DAVID RIVLIN / REPRESENTATIVE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 300 REDLAND COURT, SUITE 212. OWINGS MILLS. MD 20a. Method of Disposition Place of Disposition (Name of 20c. Location - City or Town, State ATTZ CHAIM CONG. 1 Burial 2 Cremation 3 Removal from State 05/16/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Mall be 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PHEUMONIA Immediate Cause (Final 16 days. disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FIBRILLATION No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed2 1∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient P 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

ral", or items 23a or 28a-f show Examiner must be notifled at

"natural",

ould be filed within 7 I Mental Hygiene. other than

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event;

A EN

C

Maryland 21215-0036

Baltimore.

the burial-transit attending physician as t signed by After this

Division or Vital Records, P.O. Box 68760.

Certification:

Medical

27. Manner of Death Natural

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

HOSPITAL OF BALTIMORE

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Seemyadav.

MBBS

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number RES-000 29d. Date signed (Month, Day, Year) ,2008 15

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIMAI

SUNNY YADAV, MBBS 31. Date filed (Month, Day, Year)

MAY 1 9 2008

make)

State Registrar

within 24 hours after death To the Funeral Director:

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Year Month May Physician 10, 10:00PM James M. Schoo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 10 Liberty Parkway Baltimore Dundalk 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ XM 2 □ F Days Hours 212-20-0808 84 Yrs. 10-13-1923 D.C. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location or 28a-f show "natural", or items 23a or 28a-f sho 1XYes 2 No Director Baltimore Dundalk MD 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 10 Liberty Parkway 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☆Yes 2 ☐ No If Yes, Give Year or Dates: ₩WII— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No Completed by Specify: 3 Widowed 4 Divorced Korea | 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, Item Many injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) 9 Postal Clerk 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Earl F. Schoo Nellie M. Abell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2776 Thronbrook Rd., Ellicott City, MD21042 Wayne L. Schoo - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 5-15-08 Baltimore, MD 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton Funeral Home, PA, 2134 Willow Spring Rd, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be execute the burial-tran Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No of Vital 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To nours after death, neral Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 27. Mann f Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 A atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature certifier 29c. License numbe 29d. Date signed (Monthy Day, Year) of person who completed cause of death (Item 23a) (Type, Print) Dundalk M.D. Kuma asHI 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Wayne Willard Storm 2008 May 14 11:30A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 217-50-1320 7. Age (In yrs. last birthday) **Funeral** Hours 1**X**M 2□ F Months Days Min 62 Director 01.13.1946 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 524 N. Charles St. Apt. 503 21201 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2. No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Executive Chef 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Marie Harle Kenneth E. Storm, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth E. Storm, Jř. 3216 Sunrise Dr. Jefferson, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 05.16.200 Beltsville, MD Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee CAFA/Stephen D. Lohrmann PA 8**717** Green Pastures Dr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence 1): disease or condition resulting in death) /Medical **Examiner** WIDHOL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (bras a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 2 **1**100 Director: After this certification by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No ۵ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c, License number 29b. Signature and title of certifier

State Registrar

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jnashun

Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 2:38 KM AMES THORIAS 2008 10 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Glen Burnie Glen Burnie Rehab If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 1 □ M 2 □ F Months 223-26-1130 Jun 18, 1925 Virginia 82 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TXYes 2 □ No Pasadena Anne Arundel Maryland 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 181 Mountain Road 21122 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Baltimore Loading Dock** Long Shoreman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Lee Thomas James W. Thomas Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 181 Mountain Road Pasadena, Maryland 21122 Ethel Thomas Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 05/19/08 Pasadena, Md. 4 Donation 5 Dother (Specify) Mt. Zion Church Cemeterly 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): consequence of) mul Due to (or as a consequence of). IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 2 ☐ No 9□Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

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attending physician for use as the buria

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certificate has t irector, page 2 s

after death.

I Director: After this certific d in by the funeral director,

within 24 hours aft

To the Funeral D

completely filled in

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show must be notified at

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Department of Health and Mental Hygiene. Important: If Item 27 is marked other trans any injury or other traumatic event, the Monce.

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Completed

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Medical Certification: To

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

permit.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SS 1□ Yes 2 No 3 Probably 4 Unknown

26. Place of Death (Check only one)

24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

5 Pending investigation

6 ☐ Could not be

determined

1 Inpatient 2 ER/Outpatient 28a. Date of Injury 28h Time of (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

3 DOA 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

2 🗌 No

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ertifie 29b. Signature and title

Hospital:

29c. License number

1 Tyes

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Vargosko Andrew J. 6:00p 14 2008 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Sykesville Fairhaven 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 CT 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours **№** M 2□ F Months Days 82 048-18-3346 Director Jan 28 1926 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoy ury or other traumatic event, I'm M. dicel Examination and building at Carrol1 Sykesville MD 1 X Yes 2 ∃No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21784 7200 Third Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Amed Forces? 1 TyYes 2 □ No WWII If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white <u>^</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NTHscientist +8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 421 N. Springdale Rd., Westminster, MD 21158 Lisa Petry (friend) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Importent: If any injury or ance. Sykesville, MD Springfield Cemetery 5-20-08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Daige Spaight Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Car Coment. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I my learning to mine a lacause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐ Pregnant at time of death ed by the e signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate hes b irector, page 2 sl 24a. Was an autopsy performed 1 Yes 2 No Hospital or Attending Physician: director, Be 25. Was case reterred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 →NO 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending s after decrai Director: After 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 To the th \$ 29b. Signature and title of certifier 2 00058137 MO 2 30. Name a d address of person ocompleted cause of death (Item 23a) (Type, Print 6+327 Westminster MD 21157 295 Story Kus 32 Registrar's Signature State DEALL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 15, 1. Decedent's Name (First, Middle, Last) ^{Day} 2008 Physician May 4:00P M Antonio E. Vagenos /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Heritage Genesis Nursing Home Dundalk Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Hours 1 XM 2 □ F 7-18-1923 MD Director 220-14-0856 84 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 1 Yes 2 No Director MD Baltimore City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6608 Graceland Avenue USA 14. Race - American Indian, 21224 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Boiler Operator Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Vagenos Lydia Pazakis 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael E. Vagenos-Brother 17 Talcott Ave., Vernon, CT20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5-20-08 Greek Orthodox Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bradley-Ashton Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) detached for ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 22 No has page 2 certificate 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 3□ DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier * Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

State

29b. Signature and title of certifier

filed (Month, Day, Year)

Registrar

30. Name and address of

death (Item 23a) (Type, Print)

32. Registrar's Sig

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Physician

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

/Medical **Examiner**

physician and s the burial-trans

attending pl

After this certification funeral director,

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Examine

Medical Certification: To Be Completed by Physician/Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physicia /Medic		Hilda D. Wheeler								-				05-16-	05-16-2008 Year			920	А м
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oth y	Be (17. Father's Name (First, Middle, Last)						18. Mother's Name (First, Middle, Maiden Surna						en Surnam	ne)				
uld be Menta	일	Carmello DiMaggio							Clementina Farrari										
sho and s ms		19a. Informant's Na	ame/Relations	ship (Type	e. Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
and 2		Julie Je	tt (N	iece)			442	23 F	org	e Rd	Per	ry Ha	211, MD	21	128			
oth oth		20a. Method of Disp					20b. Pla	ace of Di	ispositi	on (Nan	ne of	e) ;		Date	20c. Location - City or Town, State				
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic event, the Nedical Evapone.		1 X Burial 2 Donation			moval from	State		ace of Disposition (Name of metery, crematory or other place) t Holy Redeemer 05-1					05-19	9-2008	8 Baltimore, MD				
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21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final

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Oropharyngeal	dysphageA
ue to (or as a consequence of):	, ,
Struce Acute	
ue to (or as a consequence of):	

Due to (or as a consequence of):

3 Ectopic pregnancy

23d. Date of delivery Month Day Year

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 9 Unknown

IF FEMALE

yes, outcome of pregnancy 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown

5 Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

23e. Did tobacco use contribute to the cause of death? 2 1 No 1 ☐ Yes 3 Probably 4 Unknown

24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Approximate Interval Between Onset and Death

reeks

25. Was case referre examiner? 1 ☐ Yes 2 ☐ N	
27. Manner of Death	
1 Natural	5 Pendin

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 28d. Describe how injury

Other (Specify)	4	05.	dica
occurred	Н	7	100

6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide

2 ☐ Accident

29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29b. Signature and title of Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D25205 MAY 16, 2008

Noules St. falto. Md 2120x

30, Name and address of person who completed cause of death (tem 23a) (Type, Print) 6701

and manner stated

State Registrar 31. Date filed (Month, Day, Year) 9 2008 1

5 Pending investigation

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1610 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6-1, 320 PM 2008 May Hope Marie Ward /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F **Director** N/A 2 May 2, 2008 MD Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD <u>Baltimore</u> Edgemere 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Funeral 2715 Lodge Forest Drive USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify <u>Ş</u> Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 0 Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alan B. Ward Laurie E. Gates 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie E. Gates-Ward (mother) 2715 Lodge Forest Drive, Edgemere, MD. 21219 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Miranda</u> Cemetery 05/10/2008 Huntingtown, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Hant Z, Deutson 7922 Wise Ave. Dundalk, MD 21222 Dundalk, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Insufficiency
Due to (or as a continuence of): **Physician** disease or condition resulting in death) BINH /Medical Examiner Pulmonary Typertension BINH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Meconium attending physician and dor use as the burial-transit Aspiration Syndrome Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months? page 2 should be detached for Month Day Year 4 Pregnant at time of death 1 Yes 2 No 5 Other (specify) the 9 \to Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 2 7 10 1 Yes 2 ER/Outpatient 3 DOA P 5 Residence 6 Other (Specify) this To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Accident 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a 1 🗲 artifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00060862 May 04,2008 30. Name an oddress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Janine E. Bullard 31. Date filed (Month, Day, Year)

MAY 1 9 2008

37/Registrar's Signature

borle

600 North Wolfe St, Baltimore, MD, 21287

21215-0036

Baltimore, Maryland

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68760

Box

P.O.

Records,

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Alton L. Winston, SK 11:55 pm 2008 05 06 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Hospita Baltimore Good Samaritan 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 42 Days Hours Min. 1⊠M 2□F 214-86-5294 MDUsual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 X Yes 2 □ No MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1423 Kenhill Avenue 21213 U S 14. Race - American Indian Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. XXNever Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Disabled 12th grade N/ADisabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Winston Willie Harrington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7032 McClean Blvd Balto, MD 21234 of Disposition (Name of Date Date 20c. Location - City or Town, State Alton L. Winston, Jr-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State Arbutus Mem Park 5-13-2008 Arbutus, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility March F/H East 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 21202 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final +dvanced disease or condition resulting in death) Due to (or as a consequence f): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last umonar Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 1 ☐Live birth 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) I Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"naturai", or Items 23a or 28a-f show idical Examiner must be notified at

Director

Funeral

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Completed

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical Eonce.

sician and burial-transit certificate be executed attending physician for use as the buria page 2 should this certificate

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Completed Be မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dil Certification:

23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy performed? Yes 2 No 1☐ Yes 26. Place of Death Check onl one

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

	Was case referred to medical examiner? 1 ☐ Yes 2 No
27	Manner of Death

5 Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury 28b. Time of (Month, Day Year)

1 Nation 2 ER/Outpatient 3 DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifie

Medical

Natural

2 Accident 3 Suicide

4 Homicide

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier

29c. License number

29d. Date signed (Month, Day, Year) 05/6/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
5601 Loch raven BIVd, Bultimore, MD, 21239

31. Date filed (Month, Day, Year) 2008 9

32. Registrar's Signature

5

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 200^{Yea} Physician 15, 2:41 AM May Eldon Barter Webber /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Walkersville Glade Valley Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea. 5. Social Security Number Age (In vrs. last birthday) 1**⅓**M 2□ F 93 11, 1914 Massachusetts 019-01-3129 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Director Adamstown Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21710 United States 5395 George Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 12\$Yes 2□No1942− If Yes, Give Year or Dates: 1948 Race - American Indian Black, White, etc. 11. Marital Status Specify: White 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify. Completed by 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Government Revenue Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Mae Keene Ralph Webber ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5395 George St. Adamstown, MD 21710 Gail Martin / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 17 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Resthaven Crematory 2008 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the distance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart future. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) years Dementia Due to (or as a consequence of): Alzheimer's Disease years Sequentially list conditions, if any, leading to immediate cause. Each of John 3 Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Medical

requires that the death certificate be executed burial-trar physician the burial Division or Vital Records, P.O. Box 68760, attending p for use as as ed by the a signed b cate has certificate this or Attending

Funeral

Director

1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

al Hygiene.

h and Mental H

Pages 1 and 2.
ment of Health a.
ant: If Item 27 is.

Department o Important: If any injury or

Physician

/Medical

Examiner

within 24 hours after death To the Funeral Director:

Hospital

State Registrar 29b. Signatur

30. Name and

Allen J

31. Date filed (Month, Day, Year)

dress of person who could

Gilson, M.D.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions Renal Insufficie	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2元 No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Dea	ath (Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing H	lome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1五 Natural 5 □ Pending 2 □ Accident investigat	28a. Date of Injury (Month, Day Year) 28b. Time of Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 Suicide 6 Could not 4 Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying	Physician: To the best of my knowledge, death occurred at the time, date and place taminer: On the basis of examination and/or investigation, in my opinion, death occu	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

29c. License number

D 26516

1475 Taney Ave., Frederick, MD 21702

29d. Date signed (Month, Day, Year)

May 16, 2008

and manner stated

cause of death (Item 23a) (Type, Print)

34. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** May 16, 2008 12:47 P Arthur Lewis WEBBER [™]/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockv111e Collingswood Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 X M 2 □ F Months Yrs. 130-28-9996 Director 1936 New York June 26. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Director Maryland Potomac Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20854 United States 11107 South Glen Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: white ģ 3 ₩idowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Estelle Feinman Lawrence Webber ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10017 Westherwood Court, Potomac, MD 20854 Date | 20c. Location - City or Town, State Erica Webber, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 █ Burial 2 □ Cremation 3 □ Removal from State 500 4 □ Donation 5 □ Other (Specify) 05/19/08 Judean Memorial Gardens Olney, MD 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, nding physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 Pending investigation 1 Natural 1 Yes 2 No death. after death. | Director: / 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

within 24 hours aft

To the Funeral DI

completely filled in 15

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

Medical

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAYED EISHYTAD GF15 McCli (T 32. Registrar's Signature

😰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

62435

08-03472 David Winner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day May 6, 2008 1940 hrs **Medical Examiner** David R. Winner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) 700 Park Avenue Apartment 6A Baltimore 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Min Director 217-50-4519 1X M 2 Apr 14, 1948 Yrs Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 No or items 23a or 28a-f show must be notified at once. MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' 700 Park Avenue #6A 21201 USA 靣 Funera 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 X Never Married 2 Married Yes 2 X No Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", (injury or other traumatic event, the <u>Medical Examiner</u> I Yes 2 X No specify: white Widowed Divorced If Yes. Give Year Specify: ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done un 2 16b. Kind of Business/Industry unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ore, MD 21215-0036 es 1 and 2 should be filed within 721 of Health and Mental Hygiene. 2 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Drexel Winner Anne Windle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine M. Salam/sister 1293 Swan Drive Annapolis, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Pages 1 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other Specify 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street mature of Funeral Ronald Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and ure. List only one cause on each line /Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical XAMENDED Items 23a, Pt I, II, 27 per me, g879, 05/20/08dhb ned by the attending physician detached for use as the burial -UNPENDED Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the built. 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Alcoholism Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other, Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 ✔ Yes ٩ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Pending Yes 2 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined (Specify) Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) hw O.C.M.E. May 7, 2008

OCME 2006

Registrar DHMH 17 Rev 1/2001

Ling Li, MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		4	For State Registrar	State of Ma		ertificate of L			eg. No 2	308	161	85	
	7-7		Decedent's Name (First, Middle, La	ist)				2. Date of Deat Month	Day	Year	3. Time of De		
	Physicia /Medic		Jane I Weyrauc	h				May 6,			3:25 A	M M	
	Examin	30	4a. Facility Name (If not institution, given	e street and number)		4b. City, Town, or		1		nty of Death			
		A.	Fairhaven Nurs			Sykesv		Lab. (Bit		roll	-lana (Otata and	i	
	Funeral Director		215-32-9283	Sex 7. Age 1 □ M 2 ▼ F	e (In yrs. last birthda 78 Yrs.	y) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Dec 6,	Year)	Mary		oreign	
_	pu »	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					10d. Inside City	Limits	
	short short ad at	ō	MD Carroll		Syke	sville					1 ☐ Yes 2	X No	
	the N 28a-f	ect.	10e. Street and Number			10f. Zip Code		1	0g. Citizen	of What Cou	ntry?		
	with ta or	Funeral Director	7200 Third Avenu	e #C113			21784			USA			
	ns 23 mus	era	11, Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	3. Was Decedent of Hi	ispanic Origin? (S	pecity Yes or No-		Race - Americ			
350	d 2 should be filed within 72 hours after death with the Maryland it and Mental Hyglene. 77 Is marked other than "hatural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at traumatic event.	by Fur	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ ! If Yes, Give Year or Dates:	No	1 ☐ Yes 2 K No	Specify:	o (noan, oto.)		ecify: whi		353	
2-0036	2 hou		15. Decedent's E (Specify only highest g	ducation	16a. De	cedent's Usual Occupa ive kind of work done of b. DO NOT use retired	ation during most of wor	rking	16b. Kind of	f Business/Ir	ndustry	unk	
	e. an "n Medi	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	_							
N	filed within Hygiene. other than '	် ပ	12	5+		educato		ne (First, Middle,	Maiden Surr	name)			
D	be file	Be	17. Father's Name (First, Middle, Las					a D. Doug					
<u>₹</u>	should be tand Mental I s marked or umatic eve	မ	Edward H. Irela		19h M	ailing Address (Street					ip Code)		
, Mar	and 2 sho ealth and n 27 Is m		19a. Informant's Name/Relationship Eleanor Baumgard		er 120	56 S. Pleas	sant Val	ley Road	Westm	ninste	r, MD 21	1158	
Baltimore, Maryland 2121	of H fiter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spec	☐Removal from State	comoton: c	rematory or other plac	ce)	Date	200. Localio	on only or t			
Balti	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Lice Ronald S.	111 XM	2	22. Name and Addre State Anat Baltimore,	omy Boar MD 212	d 655 W. 01	Balti	more	Street		
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	d the death. Do not	enter the mode of dyir	ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Betw	reen	
-	Physician		Immedian Cause (Final	Fn	dometo	al ca	ncor				Onset and De	adu i	
1	/Medical		disease or condition resulting in death)		a consequence of):	or cu	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			779	0		
	Examiner			h									
	TO SERVE	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):								
	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	s a consequence of):								
Ö,	e exe ian a urial-		resulting in death) cast	Due to (or as	s a consequence or).	o of):							
68760,	ate b physic the b	edical		d									
Box	The law requires that the death certific at has been signed by the attending proage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No			3 □Ectopic pregnanc 5 □ Other (specify) □	у		23d. Date of delivery Month Da			'ear	
P.O.	at the by the	h.	9 Unknown		but not requiting in th	o underlying nause di	en in Part I	23e Did to	obacco use	contribute to	the cause of de	eath?	
	es th igned	by	Part II. Other significant conditions	s contributing to death t	but not resulting in th	e underlying cause gr	remain and a	10			obably 4 □U		
ord	een s	ted						11			utopsy findings a	available	
ec	has b	Completed						24a. Was autor perfo		prior to death?	completion of ca	use of	
E	: The	ပ္ပြဲ						1□ Yes	25No	1 □ Yes	2 □ No		
Vit	Iclan certifi ector	Be	25. Was case referred to medical examiner?	Hospital:	Service of the servic	otiont 3000A Oti	hor:	eath <i>(Check only c</i> Home 5 \subsetent		Other (Spe	ncifu)		
0	Physician: r this certific ral director,	-1 2	1 ☐ Yes 2 No	28a. Date of In	jury 28b. Tim		iry at	28d. Describe			chy)		
L _O	ding After fune	ion	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, D	Day Year) Inju	ıry Wo M 1⊑	rk?]Yes 2 □No						
Division or Vital Records,	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could no 4 Homicide determine	ad Zue. Flace ul II	njury - At home, farm etc. <i>(Specify)</i>	, street, factory, office		28f. Location (City or To		lumber or Ri	ural Route Num	ber,	
٦	To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical Ce	29a. Certifier 1 Certifying (Check only one)	Physician: To the bes kaminer: On the basis and manners	of examination and/	death occurred at the tor investigation, in my	time, date and place opinion, death oc	ce, and due to the curred at the time	cause(s) ar date and pl	nd manner as lace, and du	s stated. e to the cause(s	;)	
	To the within 2 To the comple	Med	29b. Signature and title of certifier	J MD			se number 4849)	29d. Date s		th, Day, Year)	3	
				, 7)	/ / th //to 00-) /T-				- (7)			
			30. Name and address of person w	no completed cause of	b 45 Listrar's Signature	bert y	Rd 9	E Iders	burg	MI	217	184	
	St Regis	tate trar	31. Date filed (Month, Day, Year) MAY 1 9 2	008	JA A	meli							

Williams Henrietta

P.O. Box 68760

		Registrar 1. Decedent's Name (First, Middle						2. Date of Dea Month	ith Day	Year	3. Time of Death	
ician dical			Hei	nrietta	Willi	ams		April_	30, 2	8008	12:55 P	
niner	-	la. Facility Name (If not institution				4b. City, Town, o	r Location of Deat	h		ty of Death		
	-	Greater Balti	more Medic	al Cen	ter	Towson If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	Balti	9. Birthp	lace (State or Fore	
al or		215-46-8160	1□ M 2□ x F		2 Yrs.	Months Days	Hours Min.		, <i>Year)</i> 3, 1945	Coun	maryland_	
	<u> </u>	Jsual Residence of Decedent 10a. State 10b. County		10c City	y, Town or Lo	ocation				11	0d. Inside City Lim	
à	- 1	Maryland 100. County	Baltimore	100.00	y, TOWIT OF EC		Baltimore				1 □¥ es 2 □ N	
Director	3 -	Oe. Street and Number	Balamoro			10f. Zip Code			10g. Citizen of	What Coun	try?	
<u> </u>		1918 Summit Aven	ue				21207			U.S.	A.	
Finera		11. Marital Status	12. Was Deced		S. 13.	Was Decedent of I	Hispanic Origin? (S an. Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Ra	ace - Americ ack, White, e	an Indian,	
2		1 ☐ Never Married 2 ☐ Married	ried 1 ☐ Yes 2 If Yes, Give	2 □ X °		1 □ Yes 2 □ X o			Speci		Black	
		3 ☐ Widowed 4 ☐ Divorced	Year or Dat	les:	16a Dece	edent's Usual Occu	pation		16b. Kind of I			
late		(Specify only highe	st grade completed)	45.	(Give	e kind of work done DO NOT use retire	during most of wor	rking	100.11110			
Completed	5	Elementary/Secondary (0-12)	College (1-4	401 5+)		Director	Project SAG	SA .		Baltimo	ore City	
Ro C		17. Father's Name (First, Middle,	Last)				18. Mother's Nar	me (First, Middle,				
other traumatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director			ames Randall						a F. Johr			
4	ı	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State										
	-	20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or										
		1 ☐ Kurial 2 ☐ Cremation		tate		matory or other pla	i	05/08/08	C	Owings N	tills. Md.	
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	- 1	+11	VIII Car				ood of I dolling					
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2	+	23a Part I. Enter the disease, or	r complications that ca	used the death	h. Do not er	1300	Brothers Ful	Raltimore M	id 2121/_		Approximate Interval Between	
	+	shock, or heaft failure. List Immediate Cause (Final disease or condition	r complications that ca	ch line.		1300	Brothers Ful	Raltimore M	id 2121/_	7	Interval Between Onset and Death	
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Registrar

Sparke

plasure.

MAY 1 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland Registrar #10a Per FH C879 5/19/	I / Department of Health a '08 c ul tificate of Death	and Mental Hyg	giene Reg. No. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
	CELE		Decedent's Name (First, Middle, Last)	-	2. Date of Dea	th 3. Time of Death
	Physici /Medic			HITAKER	May	11 2008 10:11 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location o		4c. County of Death
1			BON SECOURS HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. Ia			N/A 9. Birthplace (State or Foreign
h	Funeral Director		214-03-4790 1 M 2XF 95	Yrs. Months Days Hours	Min (Month, Day	7-1913 Country) Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location		10d. Inside City Limits
	Mary a-f sho	tor	Maryland 70 A Bo	eltimore City		1 🗷 ∕es 2 🗆 No
	th with the 23a or 28a ust be not	al Director	10e. Street and Number 3308 W. Franklin 8+7	ceet 101. Zip Code 2/229	}	10g. Citizen of What Country? USP
21215-0036	d within 72 hours after death with the Maryland giene. r than "natural", or items 23a or 23a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Never Married 2 Married If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Oric If Yes, specify Cuban, Mexican 1 ☐ Yes 2 ☑ No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
5-0	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	of working	16b. Kind of Business/Industry
121	within iene. than "	dmc	Elementary/Secondary (0-12) College (1-4or 5+)	Homemake		Own Home
102	e filed al Hygi other vent, t	Be C	17. Father's Name (<i>First, Middle, Last</i>)		r's Name (First, Middle,	Maiden Surname)
ılar	buld be Mental arked o	To B	George Tyre		Ma	ary Swanson
Maryland	2 should be and Menta Is marked raumatic ev		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number	er or Rural Route Numbe	er, City or Town, State, Zip Code)
	ges 1 and 2 should be filed t of Health and Mental Hyg If Item 27 Is marked othe or other traumatic event,		Weldalene Hodge	3308 West Franklin S	treet Baltimore, N	`
altimore,	ages Int of H	1	T Munai 2 Cremation 3 Removarirom State	ace of Disposition (Name of metery, crematory or other place)		20c. Location - City or Town, State
Ħ	permit. Pages Department of Important: If I any Injury or one		4 □ Donation 5 □ Other (Specify) 21. Sign turn of Funeral Servi. Lie nsep	Arbutus Memorial Park 22. Name and Address of Facility	05/17/08	Baltimore, Maryland
Ba	permi Depa Impo any Ii		Call G Esters		, s Funeral Service lace Baltimore, N	P. A.
r			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as	cardiac or respiratory ar	rest, Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	rorary fre	ery Xu	fedse Gliser and Death
10	/Medical Examiner		Due to (or as a conseque	ence of):		
1		er	Sequentially list conditions, if any, leading to immediate	rice of):		
	cuted ransit	Examine	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
o,	ficate be executed physician and street transit		resulting in death) Last Due to (or as a conseque	ence of):		
68760,	ate b	edical	d			
	certific ding p		IF FEMALE: 23c. If yes, outcome pf pregnan.	ov.		
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	death 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
	s that ned b e deta	by Pt	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death?
rds	equire en sig ould b	ed b	Morrenson And	to Cholicysti	<u>U</u> S 104	es 2 No 3 Probably 4 Nonknown
Division or Vital Records,	law re as bee 2 sho	Completed	Hyperlipideme	ia.	24a. Was a	
<u> </u>	The ate h	Com	(\	,	autop perfor 1 Yes	med2 death? 224No 1 Yes 22 No
/ita	cian: sertific setor,	Be (25. Was case referred to medical examiner?		of Death (Check only or	ne)
or	Physic this cal dire	2				ence 6 🗆 Other (Specify)
no	ding h. After funer	ion:	1 Matural 5 Pending (Month, Day Year)	28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ N		ow injury occurred
/isi	Attender: deatl	Certification:	3 Suicide 6 Could not be 28e. Place of injury - At hom	ne, farm, street, factory, office		treet and Number or Rural Route Number,
2	al or a after	erti	4 Homicide determined building, etc. (Specify)		City or Tow	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know and manner stated.			
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Month, Day, Year)
	./		PHYSICIA	N D575	43	5-11-08
	5		30 Name and address of person who completed cause of death (Item 2 P SAN DHV MD 1740 W 31. Date filed (Month, Day, Year) 32 Registrar's Signature MAY 1 9 2008	BALTIMOREST, B	ACTIMOR	E, MD 21223
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 9 2008 33. Registrar's Signature 34. Registrar's Signature 35. Registrar's Signature 36. Registrar's Signature 37. Registrar's Signature 38. Registrar's Signature 39. Registrar's Signature 49. Registrar's Signature 49. Registrar's Signature 49. Registrar's Signature 49. Registrar's Signature 49. Registrar's Signature 49. Registrar's Signature 49. Registrar's Signature 49. Registrar's Signature 49. Registrar's Signature 49. Registrar's Signature 49. Registrar's Signature	Boarle		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** John Wilson may /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE AGNES If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1**X** M 2□ F Director 216-16-1909 84 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a State 10b. County 28a-f show other traumatic event, the Medical Exercition must be nutified at Baltimore **Baltimore City** Director Maryland 10e. Street and Number 10f. Zip Code ö 1105 Lyndhurst Street 21229 or Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Black Specify 16b. Kind of Business/Industry Lever Brothers 18. Mother's Name (First, Middle, Maiden Surname) Adaisy Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1105 Lyndhurst Street Baltimore, Maryland 21229

20c. Location - City or Town, State

Baltimore, Maryland

Vest

2008

N/A

4c. County of Death

lo

Date of Birth (Month, Day, Year) Sep 15, 1923

05/15/08

Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 21217 2:20 AM

9. Birthplace (State or Foreign

10d. Inside City Limits

Yes 2 No

Maryland

Be

2

Physician /Medical Examiner

the attending physicien and use as the detached cate has been signed by page 2 should be detact this certificate has been or Attending death. Director:

Box 68760,

P.0.

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Physician/Medical þ Completed Be ၉ 27. Manner of Death Certification: Medical

e, or complications that caused the death List only one cause on each line. Due to (or as a consequence of)

College (1-4or 5+)

Unknown

Do not enter the mode of dying, such as cardiac or respiratory arrest, Coronon Due to (or as a consequence of)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Park

22. Name and Address of Facility

Chauffeur

Interval Between Onset and Death unknown

Approximate

Due to (or as a consequence of):

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 🗆 Unknown

Flementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

4 □ Donation 5 □ Other (Specify)

1 Burial 2 ☐ Cremation 3 ☐ Removal from State

12

Gladys Wilson

20a Method of Disposition

Immediate Cause (Final

disease or condition resulting in death)

23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death

4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d Date of delivery Month Day

Year 23e. Did tobacco use contribute to the cause of death?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

4 Unknown

3 Probably

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical 1 ☐ Yes 2 ☐ №6

1 Natural

2 Accident

3 Suicide

1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending

2 FreQuipatient 3 DOA 28b. Time of Injury

Cther: 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death Check only one 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

2 No

1 ☐ Yes 2 ☐ No

24a. Was an

1 Tyes

28d. Describe how injury occurred

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29b. Signature and title of certifier

investigation

6 Could not be determined

H62862

29d. Date signed (Month, Day, Year)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caton Ave. Bultimore, mD 2/229 900 S. HOSPITAL

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Gorde

State

Registrar

hours after within 24 hours a
To the Funerel (
completely filled

Coorgo E William		State of Maryland / Department of Health and Mental H	lvaiene	one.	6 1216
George E. Williams		- For State Of Maryland / Department of Health and Wertain -		200	8 16 6
Discription.	F	egistrar 1. Decedent's Name (First, Middle,Last)	Reg. 2. Date of Death	No.	3. Time of Death
Physician Medical Examine	4	George E. Williams	Month D: May 7, 2008	ay Year	1911 hrs
. 34		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat		4c. County of Deat	4
	ı	Bon Secours Hospital Baltimore		N/	A
Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	_	MM/DD/YYYY) 9. Bir Foreig	thplace (State or
Director	L	314-64-1353 1 Mm 2 F 53 Yrs. Months Days Hours Mi	Aug. 1.		ountry) Md.
	ľ	Usual Residence of Decedent	1 (2)		Table 1 of the time
v any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 Yes 2 No
and I show	5	Md. NA Baltimore			7
Maryl 28a-	ΦI	10e. Street and Number	10g.	Citizen of What Cou	intry?
h the N 3a or S	- 1	2135 Jefferson St. 21205		US	/†
then then	unera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Status Armed Forces? 14. Never Married 2 Married 2 Married Proces?		White, etc.	rican Indian, Black,
or it	크	1 Yes 2 X No		Specify: B	lack
5-0036 led within 72 hours after death with the Maryland stygener other than "matural", or items 23a or 28a-f 5th the Medical Examiner must be notified at once from the Medical Examiner must be notified at once from the form the formula of the f	⋧	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	f work done 1	6b. Kind of Business.	/Industry
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thin 7 than edical	ᆰ	12. D Tow Truck Ope	rator	Local (ompanies
5-0036 Iled within 7: Hygiene. I other than the Medical	Completed	17. Father's Name (First, Middle, Last)	ne (First, Middle, Mai	iden Surname)	,
21215 21216 Mental H Marked c event, g	8	Frank Williams. Cec		Greek	7
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene fants: If item 273 and 2 show for than "matural", or items 23a or 28a-f show or other tranmatic event, the Medical Examiner must be notified at once.	의	19a. Informant's Name/Relationship (Type, Print) (Frend) 19b. Mailing Address (Street and Number o	Rural Route Number	er, City or Town, Stat	e, Zip Code)
e, MD 1 and 2 sho Health and item 27 is		MS. Fatricia Montannery 332/ Elmley 20a. Method of Disposition (Name of cemetery)	Date 1	20c. Location - City of	r Town State
Ore, ges 1 ar of Hee If iter	-1	4 Duriel 2 V Commetice 2 Removed from State Crematory or other place)	/. / L		00.1
imor Pages nent of ant: If or othe		4 Donation 5 Other Specify: WeTro Crematory	21/2008	Balto.	Ma.
Baltimo permit. Page Department c Important: injury or oth		21. Fignature of Funeral Service Licensee 22. Name and Address of Facility	Funeral	Home P	A
	_	2273 W. Nor the 23d. Part I. Enter the disease, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arres	t shock, or heart	Approximate Interval
Physician /Medical		failure. List only one cause on each line.			Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive atherosclerotic cardiovascular Due to (or as a consequence of):	discase		
1		Sequentially list conditions, b.			
	힐	if any, leading to immediate Due to (or as a consequence of):			
	Examiner	Colsease or injury that initiated events resulting in death). Last events resulting in death). Last			
		d			
	an/Medical	AMENDED AMENDED 23a, PII, 27, perME, g880 6/4/08 TT			
iox 68760, eath certificate be a attending physici for use as the buri	Ě	IF FEMALE:		23d. Date of delive	
68 certifi	au	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	nancy	Month	Day Year
Box e death c the atten	ysici	1 Yes 2 No 9 Unknown 9 Unknown			
O. E at the d d by the etached	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?
ires that the signed by	d b	Congestive heart failure; peripheral vascular disease;	1 Yes		obably 4 V Unknown
of Vital Records, ig Physician: The law require when this certificate has been si meral director, page 2 should t	Completed	atrial fibrillation; end stage renal disease; remote cerebral	24a. Was ar autops	y prior to	autopsy findings available o completion of cause of
eco he law ite has	틹	infarct	perform 1 ✓ Yes 2		
tal Rection: The certificate		25. Was case referred to medical 26.Place of Death (Che	ck only one)		
Vita hysicia hysicia this ce	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Num	rsing Home 5 R	tesidence 6 Oth	ner:
ding Ph	Ë	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred	
ion tendi leath. tor:	읋	Natural 5 Pending 1 Yes 2 No			
Division tal or Attendii rs after death. al Director: /	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (St or Town, Sta		Rural Route Number, City
Divisior Divisior Sepital or Attend hours alber death neral Director: y filled in by the	Š	4 Homicide determined (Specify) 29a. Certifier Continue Devision To the best of my knowledge, death occurred at the time date and place a	1	(-) and manner on o	totod
	g	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	and due to the cause ed at the time, date a	(s) and marmer as si nd place, and due to	the cause(s)
Div To the Hospital or within 24 hours afte To the Funeral Dill completely filled in	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (#	
	_	0.C.M.E.		May 8, 2008	
		30. Name and address of person who completed cause of death (Item 23a)			
φ		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltim	ore, MD 21201		
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Registr	rar	MAY 1 9 2008 Julius St. Agreed			

DHMH 17 Rev 1/2001 OCME 2006

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

ľ	1 - For State Registrar		C	Certificate o	of Death		, No.2 () () ()	16190					
n al	Decedent's Name (First, Middle, La		Virginia	Alvaro		2. Date of Death Month MAY	13 2008	3. Time of Death 3:40 PM					
er	4a. Facility Name (If not institution, gi	· ·			n, or Location of De		4c. County of Dea						
	Reeders Memoria 5. Social Security Number 6.		e (In yrs. last birthd		Boonsbord			nington rthplace (State or Foreign					
	220-34-2101 1 M 2 F 69 Yrs. Months Days Hours Min. (Month, Day, Year) Feb. 15, 1939												
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits												
tor	Maryland Washi	ngton		W i 7	liamsport	-		1 🔀 Yes 2 🗆 No					
Director	10e. Street and Number	119 0011		10f. Zip Coo			g. Citizen of What C	country?					
	35 West Salis	bury Stree	t		21795		U.S.A.						
Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	13. Was Decedent	of Hispanic Origin?	(Specify Yes or No- lerto Rican, etc.)	14. Race - Am Black, Wh						
by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced		hite										
	15. Decedent's E	Year or Dates: Education	16a. De	ecedent's Usual Oc	ccupation	10	6b. Kind of Busines	s/Industry					
plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clive kind of work done during most of working life. DO NOT use retired)												
Completed	12		,	Sales Ma			Liquor S	Store					
Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)												
2	Lawrence Horn Violet Sirbaugh												
	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
	Jacqueline A. Smith (Daughter) 17926 Garden Lane Hagerstown, Maryland 21740												
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. May 15,												
	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Removal from State Cemetery, crematory or other place) May 15, Smithsburg Crematory 2008 Smithsburg, Maryland												
	21. Signature of Funeral Service Licensee Smithsburg Crematory 2008 Smithsburg, Maryland 22. Name and Address of Facility J.L. Davis Funeral Home												
	Jeffer Jours Mo14/4 12525 Bradbury Ave. Smithsburg, Maryland 21783												
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
		shock, or heart failure. List only one cause on each line.											
	Immediate Cause (Final disease or condition METASTATE LUNG CANCER												
	disease or condition resulting in death)				CANCER			2-3 Marth					
	disease or condition	Due to (or as	a_consequence of):	:	CANCER			2-3 Months					
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State Registrar

DHMH 17 Rev 1/2001

DR. GHAZALA QADIR
31. Date filed (Month, Pay, Year)
MAY 1 9 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

Funeral

Director

show

ns 23a or 28a-f sh must be notified

iral", or items ?

"natural" er than "nature the Medical E

other

is marked

traumatic

Department of Health ar Important: If Item 27 Is any injury or other trau

Physician /Medical

death with

Pages 1 and 2 should be filed within 72 hours after on nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical Be 1 Yes 2 No P 27. Manner of Death Certification: 1 Natural 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TRANK W. HASSEN M.D. SCI TO COHOUSE OVE, FREDERICK,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of M		artment of		and Mental Hy	giene Reg. No. 2 0 0 8	16192
			Decedent's Name (First, Middle, Last	et)				2. Date of Dea	ath	3. Time of Death
	Physici		Ivan Leo Ausherma	n				Month April	29, 2008	6:33 a. M
201	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town	, or Location of		4c. County of De	
	Examin	er	Homewood Nursing	·			lliamsp		Washi	ington
-70	Funeral		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. last birthda)	If Under 1 Yea	ar If Under 2	4 Hrs. 8. Date of Birt		irthplace (State or Foreign
	Director		214-09-6089	⊠ M 2□F	89 Yrs.	Months Day	ys Hours	April 1	0, 1919	Maryland
	ס		Usual Residence of Decedent							
	rylan how	_	10a. State 10b. County		10c. City, Town or L	.ocation				10d. Inside City Limits
	e Ma	cto	Maryland Washir	gton	Hagers	town				1 ☐ Yes 21K No
	or 28)ire	10e. Street and Number			10f. Zip Cod	е		10g. Citizen of What C	Country?
	th wi	Funeral Director	19925 Trengail H	Road			21742		USA	
	ems	Inel	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of	of Hispanic Orig	gin? (Specify Yes or No- , Puerto Rican, etc.)	- 14. Race - An Black, Wh	
98	or it	E N	1 ☐ Never Married 2 Married	1 X Yes 2 ☐ : If Yes, Give	No	1 ☐ Yes 2 🕅 N		,		white
8	ural"	d by	3 Widowed 4 Divorced	Year or Dates:	WW II					
21215-0036	"nat	Completed	15. Decedent's Ed (Specify only highest gra	ucation de co <i>mpleted)</i>	(Giv	edent's Usual Oc e kind of work do	ne during most	of working	16b. Kind of Busines	s/Industry
12	vithir ene. than	ם	Elementary/Secondary (0-12)	College (1-4or 5	5+)	DO NOT use ret		inspector	aircraft	mfa
d 2	Hygik Hygik ther		17. Father's Name (First, Middle, Last)	0	Jigi	Juliuci (r's Name (First, Middle,		
an	l be f	Be	John David Ausher	man				Cora Mae H		•
Z	hould d Me mark matic	ဥ	19a. Informant's Name/Relationship (10h Mai	ling Addross /Str	and Numba	r or Rural Route Number		Zin Code)
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, fre Medical Examinar must be notified at once.		Ruth M. Ausherman					, Hagerstow		
Ġ,	1 an Heal Hem 2		20a. Method of Disposition	WIIC				Date	20c. Location - City of	
Baltimore	ages nt of r. if it		1 X Burial 2 ☐ Cremation 3 ☐		20b. Place of Disposer Commetery, cre			5/3/08	•	
Ē	it. P.		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licen		Rest Hav		<i>y</i> ,	MINNICH H		n, Maryland
Ba	permi Depar Impor any Ir		21. Signature of Funeral Service Licen	mm				lvd., Hager		
			23a. Part 1. Enter the disease, or comp	ji jun						Approximate
			shock, or heart failure. List only	one cause on each li	ne.				٨	Interval Between
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. (f/U	MC UBS	THECIE	E 14	ccurating	Davise	1 CM
	Examiner			Due to (or as	a consequence of):		0			
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	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (01 00	a 001100 40 01100 017.					
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687	ficate g phy s the	edical		d						
Box	leath certific attending p	N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of d	elivery
ğ	death atte	cial	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a		☐ Ectopic pregna ☐ Other (specify)			Month	Day Year
P.O.	the c	Physician/Me	9 Unknown	9 Unknown						
т. П	res that the de signed by the a be detached t		Part II Other significant conditions of	ontributing to death b	ut not resulting in the	underlying cause	given in Part I.	23e. Did to	obacco use contribute	to the cause of death?
rds	quires n sign lld be	D D	HTMAR FIBRE	CCATION	& VIASTO	uc Ho	SAT	1 1 1	res 2 □ No 3 □	Probably 4 Number
Records,	w require s been sig should b	Completed by	FAILLIAGE (ENHAC L	111m1A.	THAIM	PALLET	24a. Was	an 24b. Were	autopsy findings available
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of Vital	ifficat or, pa		25. Was case referred to medical				26 Place	1 ☐ Yes of Death (Check only o	*	es 2 No
>	s cert) Be	examiner?	Hospital:	ent 2 ER/Outpatio	ant 3 🗆 DOA	24	rsing Home 5 Resid		- aife)
of	ding Physician: The Ih. h. After this certificate h. funeral director, page	n: To	27. Many fer of Death	28a. Date of Inju	iry 28b. Time	of 28c. Ir	njury at		now injury occurred	oechy)
Division	th. Funde	ţi	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y, Year) Injury		Vork? □Yes 2□N	No		
is!	Atter r dea sctor	ifice	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inj	ury - At home, farm, s c. (Specify)	treet, factory, offic	ce	28f. Location (5	Street and Number or	Rural Route Number,
Ö	al or s afte I Diru	Certification:	4 ☐ Homicide determined	building, et	с. (Specify)			City or To'v	vn, State)	
	spits hours nera y fille							d place, and due to the		
	To the Hospital or Attending Physician: The law requires that the death certifing thin 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one) 2 Medical Exam	iner: On the basis of and manner st		investigation, în m	ny opinion, deal	th occurred at the time,	date and place, and d	ue to the cause(s)
	To the withing to the country of the	ž	29b. Signature and title of certifier	k	X	29c. Lice	ense number		29d Date signed (Mo.	nth, Day, Year)
			118 14A	MEDICHT	1) Intera	1 101	706		HONCC 29	1,2008
			30. Name and address of person who	completed cause of q	eath (Item 23a) (Type	Print)	1/		11/1/	1
0	Hlet/		STEPHEN E. HAETE	Wer, MI	1 13424	(alto	E HA	GENTOUN	4 Md c	1742
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	hall s			/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMIN TIP #8, per H, 0881, 7/25/08, ws
State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #8, perFH,C880 6/24/08 TT Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day A^{M} **Physician** 2008 3:02 12, May BARTLETT ELVIN /Medical EDGAR. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Frederick Memorial Hospital
Social Security Number 6. Sex 7. Age (I 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 □ F Maryland 219-05-8882 89 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10h. County 10a State 1 ☐ Yes 2 ☑ No Adamstown Director Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. United States 21710 5321 Doubs Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. MYes 2□No World fYes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Baltimore, Maryland 21215-0036 Specify: White ģ War II 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpentry Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Octavia Meitzler Edgar Franklin Bartlett ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1919 C Buckeystown Pike, Adamstown, Maryland 21710 Ronnie Bartlett / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Saint Paul's Episcopal 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 16, 2008 Point of Rocks, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 21. Signature of Funeral Service Licensee 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** V. Tack /Medical Due to (or as a consequence of): **Examiner** MOURS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760,公 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 □ No 2 ☑ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 N 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Impatient 2 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner death 28c. Injury at Work? Certification: Injury 1 Latural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide filled within 24 hours a To the Funeral I 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Kaza MDD66166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Menne Hor nite 3. Registrar's Signature 31. Date filed (Month, Day, Year) State 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylar	•	artment of Hertificate of D		lental Hy	giene Reg. No.	2008	5	94
Н	Physici	an	Decedent's Name (First, Middle, La.	st)				2. Date of De Month	Day		3. Time of	Death
	/Medic		Elaine Agnes Burd	ette				May 3,			2:00	A ^M
	Examin	er	4a. Facility Name (If not institution, give	a street and number)		4b. City, Town, or I	Location of Death		4c.	County of Death		
			Northampton Manor			Frederic	k If Under 24 Hrs.			rederic		·
	Funeral Director		5. Social Security Number 6. S 220-88-9404	I M SIME		If Under 1 Year Months Days	Hours Min.	8. Date of Bi	av, Year)	Cot	place (State or intry)	roreign
is a			Usual Residence of Decedent	88				Jan. Z	3, 15	20 Mary	land	
	yland Now		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					10d. Inside Cit	y Limits
	Mar.	to	Maryland Carroll	Mour	nt Airv					ĺ	1 X Yes	2 🗆 No
	h the	lrec	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Cou	intry?	
	death with the Marylan oma 23a or 28a-f ahow if must be positived at	aiD	407 Park Avenue			21771			USA			
	- dea	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of His If Yes, specify Cuban	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Amer Black, White		
36	or It	by Funeral Directo	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2X No	Specify:			Specify:		
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Itema 23a or 28a-f ahow event, if a Mydical Eraciliar must be notified at	d b		Year or Dates:	16a Dass	dent's Usual Occupa	tion		16h Kir	Whit nd of Business/li		
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0	ifiled will Hygien other th	Bec	17. Father's Name (First, Middle, Last,			1	18. Mother's Nam	e (First, Middle				
Maryland		ToB	Joseph Stanislaus	MacKenzie			May Ruth	Twenty	,			
a	should I and Meni is marke	-	19a. Informant's Name/Relationship (19b. Maili	ng Address (Street a				Town, State, Z	p Code)	
	s 1 and 2 should if Health and Mar item 27 is marks other traumatic		Carolyn King, dau			ark Avenu		Airy,	Mary.	land 2	1771	
o G			20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Bemoval from State	Place of Dispo cemetery, crei	sition (Name of matory or other place)	Date	20c. Lo	cation - City or T	own, State	
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Baltimore,	permit. Pege Depertment of Important: If any injury or once.		21. Signature of Funeral Service Licer	1500	22	2. Name and Address	s of FacilityMo1	esworth	-Wil	liams Fu	ıneral	Home
	10 E 3 0		yaun.	Luger		6401 Ridg				aryland	20872	
L			23a. Pan 1. Ent if the disease, or com shock or part failure. List only	plications that caused the deal one cause on each line.					arrest,		Approximate Interval Bet Onset and I	ween
	Physician		Immediate Cincs (Final disease or condition	a/	lake	ines	Demo	erlea		/	worths -	
Н	/Medical Examiner		resulting in death)	Due to (or as a consec	que of):							
	A	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	maries At							
	ted nsit	nine	Cause (Disease or injury	Dag to (5) as a \$511560	jubilité dij.							
	al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	tuence of):							
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õ	tificat ig phy es th	Physician/Medicai										
ROX	eath certific attending p I for use es t	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnature 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			2	23d. Date of deli-	,	
	deat	sicis	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of o		Other (specify)				Month	Day Y	/ear
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ö	Phys rthis ral di	. To	1 ☐ Yes 2 📉 No 27. Manner of Death	1 Unpatient 2L	28b. Time o	IL 3LI DOA	4 De ivursing Ho	ome 5 Res 28d. Describe		Other (Spec	ify)	
o	ding f th. After funer	ţ	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Work	? 'es 2 □ No			,		
DIVISION	or Attendestresser director:	fica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injury - At h	ome, farm, sti	reet, factory, office				d Number or Ru	ral Route Num	ber,
É	e efte	Certification:	4 Homicide determined	building, etc. (Specia	(y)			City or To	wn, State,)		
	To the Hospital or a within 24 hours etter To the Funeral Dire completely filled in E		29a. Certifier 1X Cartifying Pt	ysician: To the best of my kno	owledge, deat	h occurred at the time	e, date and place,	and due to the	cause(s)	and manner as	stated.	
	he Ho in 24 he Fu	Medical	(Check only 2 Madical Exar	ninar: On the basis of examina and manner stated.	ation and/or in	vestigation, in my op	inion, death occur	red at the time	, date and	place, and due	to the cause(s)
	To the within 2 To the complex	Σ	29b. Signature and title of certifier	MILLE		29c. License	number			e signed (Month		
				nec -	M	D26499)		5 -	5-0	5	
	5		30. Name and address of person who									
			Ronald E. Miller,	MD, 4 Culwell	Drive	, Mount A	iry, Mar	yland_	2177	1		
	Sta Registr		31. Date filed (Month, Day MAY 0	5 2008 Registre's Signa	K	Coule						
						7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amended#23perMD FCHD, KS Certificate of Death Reg. No. 4 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 28, 2008 Year April Physician 4.28 PM LOU BURDETTE BETTY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick 792 Wembly Dr. - Apt. - F 8. Date of Birth (Month, Day, Year) FEB. 1, 1940 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🛛 F Pennsylvania 215-36-7108 68 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State show 28a-f shov notified at Frederick 1X Yes 2 No Frederick Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or must be r 21701 792 Wembly Dr. - Apt. - F . United States Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) phone answering service Phone service - operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Shorb Perry ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4044 Trego Rd./ Keedysville, Maryland John L. Burdette, Jr. / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem.Garden 05/02/2008 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike/ Frederick, MD 21702 Raymond 23a. Part Epier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line **Probable** Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) The Condial Injactor **Physician** /Medical Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnapt 3 Ectopic pregnancy Month Year in the past 12 month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ OSTEO ON PLUTIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 2 No 25. Was case referred to medical 26. Place of Death Check onl Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To this , 24 hours after death.

e Funeral Director: After thi letely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Hospital 29a. Certifier 1 Le Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

r. Syed W. Hagye

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 3 VO 2008 L

100 32. Registr 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	-		tificate of L		-	Reg. No		16196	
ľ	Physicia	an	Decedent's Name (First, Middle, L. ANNIA	ast)		DE	CIZM A NI		2. Date of De Month	Da	ay Year	3. Time of Death	
	/Medic	al	ANNA 4a. Facility Name (If not institution, gi	ve etreet and number)		DE	CKMAN 4b. City, Town, or	Location of Death	April		2008 c. County of Death	11:00 A M	
	Examin	er	Tranquillity a		ktowne		Freder				Frederic	k	
	Funeral Director		5. Social Security Number 6. 219-16-2678		(In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da April	th ly, Year 30,1	9. Birthplace (State or Forei Country) 10,1924 Mary Land		
	land ow it		Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	or Loc	cation					10d. Inside City Limits	
	Mary a-f sh ifled a	tor	DE Sussex	2	S. Be	etha	any Beach					1∭Yes 2∏No	
	th the or 28; e not	Director	10e. Street and Number				10f. Zip Code			10g. Ci	itizen of What Cou	ntry?	
	ath wi		7 North 1st	St.		Lie	19930		7. V.		ited Sta		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Decedent of Hi f Yes, specify Cuba I □ Yes 2☑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity yes of No Rican, etc.))	Black, White	etc.	
5-0	72 hc 'natuı dical	eted	15. Decedent's l (Specify only highest g	ducation rade completed)	16a.	(Give .	lent's Usual Occupa kind of work done o	luring most of work	ing	16b. k	Kind of Business/Ir	ndustry	
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0 0	il Hygi I Hygi other ent, ti	Be Co	17. Father's Name (First, Middle, Las	t)			F	18. Mother's Nam	e (First, Middle				
<u>lan</u>	uld be Menta rrked ric ev	To B	John l	E. Sta	mm			Anna	Rebecca		Dieh1		
Maryland	2 sho and 1 is ma is ma		19a. Informant's Name/Relationship	(Type. Print)			g Address (Street a					*	
	1 and iealth im 27 ther tu		Bria Lawrence / 20a. Method of Disposition	Daughter			H, Dayto		Frederi Date		Maryland Location - City or T		
Baltimore,	it. Pages in the number of he refault. If ite		1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	ify)		er	sition (Name of natory or other place Crematory	Apri	30,08	Fre	derick, l	Maryland	
Ba	permi Depar Impor any Ir		(Maymond)	Peters	n)	1	Name and Address	umtown P	ike/ Fr	edei	eral Home	21702	
	Physician /Medical		23a. Part1 Inter the disease, or co shoot, or heart failure. List onlimmed the Cause (Final disease or condition resulting in death)	a INTX	ACRAI	NI	er the mode of dyin	g, such as cardiac	or respiratory a	srrest,	egure	Approximate Interval Between Onset and Death	
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P.O. Box 6	The law requires that the death certifite has been signed by the aftending lage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				23d. Date of deli	very Day Year	
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	30		30. Name and address of person whe	MD 801	eath (Item 23a)	(Type,	e Ave	D-1, 7.	REDERI	CK	, md	2008	
	Sta Registi		31. Date filed (Month, Day Year)	0 2008 Regist	,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 **Physician** 7:11 РМ APRIL 30, ROMAN ALBERT BERGANSKI /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bowie Health Center Prince 6 Bower Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 XM 2 □ F 320-22-7549 OCT. 16, 1930 ILLINOIS Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ant: If item 27 is marked other than "natural", or Items 25a or 28a-f show up or or other traumatic event, the Medical Eximiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 □ No Directo PRINCE GEORGE'S BOWIE MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20715 3806 WINCHESTER LANE Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates! 48— '71 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 XNo Specify: WHITE Specify. à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) FEDERAL GOVERNMENT POSTAL CARRIER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRANCIS KRAFT ROMAN ALBERT BERGANSKI, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3806 WINCHESTER LANE BOWIE, MD 20715 DORA BERGANSKI/ WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) METROPOLITAN CREMATORY 1 ☐ Burial 2 XCremation 3 □Removal from \$tate permit. Page Department o Important: If any Injury or once. 4 □ Donation 5 □ Other (Specify) 5/4/2008 ALEXANDRIA, VA 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME 21. Signature of Juperal Service Licenses 16000 ANNAPOLIS ROAD BOWIE, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) ☐ Yes 2☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

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To the Funeral Director: After thi
completely filled in by the funeral i

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Complete				24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
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ation: 1	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred
ertification:	3 Suicide 6 Could not be determined		factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
edical C		Physician: To the best of my knowledge, death oc aminer: On the basis of examination and/or inves and manner stated.		and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
₹	29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001

Yes

MAY 0 2 2008

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death
Month
April 2 3. Time of Death 29^{Day} Physician 200[°]8° 5:00 P Audrey M. Baker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CarrollCounty 4620 York Road Manchester If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 💢 F 69 Yrs 212-36-3945 Director Feb. 20, 1939 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 23a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Carroll County **Funeral Director** Manchester 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4620 York Road 21102 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leo Herman Crouse Madeline Donelly ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa A. Kaufman - daughter 1209 Circle Drive Halethorpe, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 30, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation Hampstead, Maryland 4 □ Donation 5 □ Other (Specify) 2008 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licenses M00741 934 South Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** OPONDEY /Medical Due to (or as a consequence of): **Examiner** NPE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 1No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 No 1 Yes Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

the burial-tran

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certified 00036231

Heted cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) AMU 30, 2008

30. Name and address of person who

N. CHARLES ST. SUITE 6701 DICKE 31. Date filed (Month, Day, Year)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 Month Physician Barksdale Randolph Lewis 6:23 P M April 27, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Southern Maryland Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 05/19/1957 Days 1□M 2□F Months 50 Washington, DC 578-80-4555 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10h Count 10d. Inside City Limits 28a-f show Examiner must be notified at 1XYes 2 No MD PGSuitland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö U.S.A. 6114 Auth Road 20746 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. nt: If item 27 Is marked other than "natural", or iten 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Private 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Lee Barksdale Loufannie Adams ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6114 Auth Road; Suitland, Maryland 20746 Carol A. Barksdale - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or otl 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 05/02/2008 Suitland, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part 7. Enter the disease, or com shock, or heart failure. List only Immediate Cluse (Final disease or condition resulting in death) icalions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nelicause on each line. Approximate Interval Between Onset and Death **Physician** Luncer -479 /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of Examiner Bradyfordia The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) P.O. I been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s autopsy performed certificate 1□ Yes or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 21 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA nours after death.

Inerat Director: After this y filled in by the funeral di 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral the Hospital critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Deficientlying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Deficientlying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 006

State Registrar

31. Date filed (Month, Day, Year) MAY 0 2 2008

, MD

Mathur Mano

5801 Allentown Road #500; Campsprings, Maryland
32. Registra's Signature

State of the Company o

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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quires that n signed build be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying the support of				nderlying ca	ause give					use contribute to the cause of death? PyNo 3□ Probably 4□Unknown				
	Completed by										- 1 - ;		utopsy prior to completion of ca erformed? death?			s available cause of
r Attending Phy ter death. Irector: After this by the funeral d	Certification: To Be	examiner?	1 Yes 2 No Hospital: 1 In Inpatient 2 ER/Outpatient 3 DOA 7. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be 28e. Place of Injury At home, farm, street, factory, office.							4 Nursing Home 5 Hesidence 6 HOther (Specify)				umber,		
To the Hospital or At within 24 hours after d To the Funeral Direc completely filled in by	edical Co	29a. Certifier (Check only one)	1 ☑ Certifyin 2 ☐ Medical	Physician: To the Examiner: On the b and man	e best of my kno easis of examina ner stated.	wledge, death	h occurred vestigation	at the tin , in my o	ne, date a pinion, de	nd place, ath occur	and due to	the cau	se(s) and me and place,	nanner as s , and due t	tated.	e(s)
To the within To the comple	Me	29b. Signature and	title of certifier	, M.D.			290 T	: License	e number 29d. Date signed (Month, Day, Year) 5-3-2008)			
4	State	30. Name and add PRATIMA 31. Date filed (Mor	A PANI			W. 7th		et,	Fred	eric	k, Ma	ry1a	nd 2	1701		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** JEANNE WATSON COCKEY APRIL 2:30PM M 27 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 23310 MAPLE HALL ROAD CLAIBORNE TALBOT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 2, 1929 Birthplace (State or Foreign Country) GEORGIA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 F 78 Yrs. Director 577-42-0918 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or items 290 ----- any injury or other traumatic event, the Marie 17 is 18 marked other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2**X** No Director TALBOT CLAIBORNE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21624 USA 23310 MAPLE HALL ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo þ Specify: WHITE 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DOROTHY MINTER ANDREW LEONARD WATSON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA J. MARSHALL/DAUGHTER 9185 HONEYSUCKLE DRIVE, EASTON, MARYLAND 21601 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State CHESAPEAKE CREMATION CTR 4/29/2008 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 31. C.F.S.P. Cstrowsh. 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4r.11 mos /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter the configuration (Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical the as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 pronths? 1 Yes 2 No 9 Unknown Month Day Year 5 ☐ Other (specify) det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an

should I certificate ha funeral director, this After

Division or Vital Records, P.O. Box 68760

Completed by To Be Medical Certification:

ours after death. To the Hospital o within 24 hours aff To the Funeral Di completely filled in

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or Attending Physician;

25. Was case referred to medical

27. Manner of Death 5 ☐ Pending investigation determined

6 ☐ Could not be

(Month, Day Year)

28a. Date of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

1 ☐ Yes 2 ☐ No

28b. Time of

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

perform

28d. Describe how injury occurred

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID SMITH M.D., 8221 TEAL DRIVE, SUITE 302, EASTON, MD 21601

31. Date filed State Registrar

1 Yes

Natural

3 ☐ Suicide

29a. Certifier

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier



Registrar DHMH 17 Rev 1/2001

State

completely

WJL

29b. Signature and title of certified

ICK 31. Date filed (Month, Day, Year) 102

and manner stated.

Sulte

32. Registrar's Signature

MULAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

10ENZ

0 1

29c. License number

20806

29d. Date/signed (Month, Day, Year)

LIBERTY RD EDERSBURG OF 21784

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month Day Year Physician May 2008 01:44 PM Eugene Ray Cox /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cecil Union Hospital of Cecil County E1kton If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 227-28-0093 1**X** M 2□ F 79 **Director** May 11, 1928 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Maryland Cecil E1kton 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 836 East Old Philadelphia Road 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√XNo Specify: Specify: White ξ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Equipment Operator Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude R. Cox Esther Price 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie Mae Roark / Sister 511 Tamara Circle, Newark, Delaware 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot Forth East Methodist May 7, 2008 North East, Maryland Cemetery ty Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Septice Line is 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** myocad wite resulting in death) /Medical Due to (or as a consequence of): **Examiner** COPP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient Certification: To 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral D 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar In cel wa

Year)

31. Date filed (Month, Day,

MD

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 04am 2008 Christine Pennock Clary lav 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Medica Plata 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) 1 Year | If Under 24 Hrs. If Under (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1□ M 2 F Months Days Hours Min. GA 454-22-0253 83 April 29,1925 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Charles 1 ☐ Yes 2 ▼No Waldorf 10f. Zip Code 10g, Citizen of What Country? 10e, Street and Number 3363 Justice Court 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 📉 No Specify. Specify. White 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leonard Pennock Eualaia Hartly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20602 Sandy Gamble/Daughter 3363 Justice Court,Waldorf, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem. 5/7/08 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 21. Signature of Funeral Service Licensee M00945 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. Tchul an 211 St. Mary's Ave. La Plata MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequente of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 X No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 217 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Physician /Medical **Examiner** Examine or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

tems 23a or 28a-f show must be notified at

'natural", or

than

Pages 1 and 2 should be filed vertent of Health and Mental Hygie ant; If item 27 is marked other i injury or other traumatic event,

permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau

Funeral

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Completed

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with the Maryland

filed within 72 hours after

21215-0036

Maryland

Baltimore,

aftending physician been signed by certificate | this After t

Be

Certification: To

Medical

Division or Vital Records, P.O. Box 68760,

Physician/Medical IF FEMALE: þ Completed

Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

29c. License number D0061652 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite 101 Waldorf MD 20605 Atul Katyal M 31. Date filed (Month, Day, Year) 32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

hours after death uneral Director: filled in by the

within 24 hours at To the Funeral C Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2008 Walter A. Camp, Jr. May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 4 mon SILVA OSMES P540 Kimloch 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**X** M 2□ F New York November 5,1928 79 Director 578-40-6414 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County 28a-f show ns 23a or 28a-f show must be notified at 1 ☐Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20903 U.S.A. 10429 Kinloch Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. , or 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify. Specify ģ Year or Dates:1950-1952 3 Widowed 4 Divorced White "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Is marked other than Ž Nutrition Retail Health Foods 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frieda Marcus Walter A. Camp, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau Zora Camp/Wife 10429 Kinloch Road, Silver Spring, Maryland 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery 05/05/2008 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or comerications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** moral /Medical Due to (or as a consequence o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation UNK AM may 1 2008 1 Yes 2 No 2 Accident

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Saltimore, Maryland 21215-0036

Certification: To filled in by

Medical

hours after death uneral Director: within 24 hours a To the Funeral C

2 144

Self in Stilled 30m) hot noun (28t. Location (Street and Number or Rural Route Number City or Town, State) 15429 Kindoch Ky 6 ☐ Could not be Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 2 sucoy 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

(Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number gnature and title of certifier

mo ome 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1001

BRECHER MO DOME

31. Date filed (Month, Day, Year) State 0 5 2008



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 20	08 16207									
Dhusia	ia	1. Decedent's Name (First, Middle, Last) 2. Date of Death	. 3. Time of Death									
Physic /Med		Rose Corsillo May 1, 2008	5:45 a M									
Exami	ner		4c. County of Death Montgomery									
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 100 7. Age (In yrs. last birthday) 100 Yrs. 1 Nonths Days Hours Min. Months Days Hours Min. March 28, 1908	Birthplace (State or Foreign Country) Maryland									
f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 □ Yes 2 No									
r 28a-	Director	Maryland Montgomery Silver Spring 106. Street and Number 106. Citizen of What	at Country?									
th with	a D	3310 N. Leisure World Blvd. Apt. 221 20906 USA										
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evanchar roust be notified at once.	by Funeral	Specify: Sp	American Indian, White, etc. hite									
21215-0036 d within 72 hours aff giene. er than "natural", or the Medical Exerci-	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busing the Local Not use retired life. DO NOT use retired life. DO NOT use retired life. DO NOT use retired life.										
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d be fi	o Be	©										
nd 2 should be file th and Mental Hy 27 is marked other traumatic event	ပ	19a. Informant's Name/Relationship (Type. Print) Charles F. Corsillo/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 3310 N. Leisure World Blvd. #221,										
nore, ages 1 and of Heal t: If item 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - Cit May 5,	ty or Town, State									
Saltimore, permit. Pages 1 ar Department of Hec Important: If item any Injury or othe		21. Signature of Funeral Service Licensee Francis Address of Earlity ins Funeral Home In										
_ 452.60		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										
Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atheroscerotic Cardiovascular Disease Due to (or as a consequence of):	Approximate Interval Between Onset and Death years									
ecuted and transit	l Examiner											
± 00 €	n/Medical	d	of delivery									
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w requires that s been signed t should be deta	5	That is, Other significant containous contributing to death but not resulting in the differing cause given in Part i.	ute to the cause of death?									
The la ate has page 2	Completed	24a. Was an autopsy performed? dea	re autopsy findings available or to completion of cause of the									
sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?										
Phys r this	5.	1 Inpatient 2 EH/Outpatient 3 DOA 4X Nursing Home 5 Residence 6 Other	(Specify)									
I or Attending Phy after death. Director: After this d in by the funeral d	cation	27. Manner of Death MSNatural 5 Pending investigation 3 Suicide 6 Could not be Could n										
ital or At its after or al Direct led in by	Certification:	4 Homicide determined determined determined 296. Place of injury - At nome, farm, street, factory, office building, etc. (Specify) determined 296. Place of injury - At nome, farm, street, factory, office 296. City or Town, State)										
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.	er as stated. I due to the cause(s)									
To t With To t	Σ	29b. Signature and title of certifier 29c. License number D43222 May 2, 2008										
, >		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charlene Ozanne-Blankfard, MD 3305 N. Leisure World Blvd., Silver	Spring, MD 20									
Sta Regista		TOTAL OF THE PARTY										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7 2<u>008</u> **Physician** Month 27 6:12 A Margaret Elizabeth Crawford April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington County 7 Winter Street Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F Hours Director 218-24-1972 81 16,1926 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f shov 1 ☐ Yes 2 No Director Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 21740 U.S.A. 7 Winter Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 □Yes 2 No Specify. White 3 Nidowed 4 □ Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'amy injury or other traumatic event, Item 2000. Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nellie Irene Stuller Smith Oscar Smith, Sr. ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12021 Heather Dr. Hagerstown, MD 21740 Kimberly Kretzer-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Lawn Mem. Park Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5-1-2008 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses Kaite 1331 Eastern Blvd. North Hagerstown, MD 21742 aron 23a. Part 1. Enter the disease, or complication, in it caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical nunth Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a d be detached fo 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Records, ≥ icate has been signated by page 2 should by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No or Attending Physician: The certificate Division of Vital 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 ☐ Other (Specify) this Certification: To After th 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fune 5 Pending investigation Natural 1 ☐Yes 2 Accident 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

3H-5

State Registrar 29b. Signature and title of certifier

Name and address of person

ted cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

08-03249 A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Adrian Chapin		1- For State	State o	f Maryla	nd / Depai <i>Cert</i>	rtment of tificate of		and	Mental Hy		Reg. No.		08 620	
Physicia		Registrar 1. Decedent's Name (First, Mi	ddle,Last)							2. Date of De	ath	Year	3. Time of Death	
Medical Examin										Month April 27,	2008	Teal	1719 hrs	
		4a. Facility Name (if not institu			nber)	1			cation of Death			. County of Deat	l l	
		1001 Mt. Airy Road					Davidso	nville			1	Anne Arunde		
Funeral	╗	5. Social Security Number	6. Sex		7. Age (In yrs. la	st birthday)	If Under 1		If Under 24Hrs.	8. Date of E	Birth (MM	/DD/YYYY) 9. Bi	rthplace (State or Foreign ountry)	
Director	l	223-49-7533	1 X A	1 2 F		20 Yrs		Days	Hours Min.	1/5/1	988		everly, MD	
4		Usual Residence of Deceden				20				1 1 3 / 3	2700	101.	3, 12	
any	1	10a. State 10b. Cour			10c. City,	Town or Locat	ion						10d. Inside City Limits	
* ,		MD Ann	e Aru	ndo1	n _s	avidsor	willa						1 Yes 2 X No	
rylan	용	10e. Street and Number	e Alu.	nuer	1 1/2	av 10501	10f. Zip Co	de			10g. Cit	izen of What Co	untry?	
e Ma or 28	Director	1001 16	-					210	125			U.S.A		
ith th		1001 Mt. Air			edent Ever in U.S	S 13 Ws	s Decedent o		בכנ anic Origin? (Sp	ecify Yes or N	No-		rican Indian, Black,	
ath w	uneral		Married	Armed Fo	rces?	If Y	es, specify C	uban, N	Mexican, Puerto	Rican, etc.)		White, etc.	, , , , , , , , , , , , , , , , , , , ,	
er de	₩.		Divorced If	1 Yes Yes, Give Yeer	2 X No	1	Yes 2 X	No	snecify:		!	Specify: Wh	ite	
rs aft ural"	ð	15. Decedent's Education (\$		or Dates:					n (Give kind of w	vork done	16b.	Kind of Business		
"hour"	ted	Elementary/Secondary (0-		College (1					O NOT use retir					
36 vin 73 than dical	ad	Elomonia y cocondary (o	,	1	,		C+1	ıden	.+		(College		
- With	Completed	17. Father's Name (First, Mid	dle. Last)				311		.Mother's Name	(First, Middle				
1.15 al Hy ed of	Be C	•							Renee B	rinton				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	일	Wayne G. Ch.	apııı onship (Tyr	e, Print)		19b. Mailin	g Address (City or Town, Sta	te, Zip Code)	
MD and 2 shoulfth and m 27 is aumatic		Renee B. Ham	mond	Motho	r	7						e, NC 2		
and 2		20a. Method of Disposition	iiona,	Mothe	20b. F	Place of Dispos	sition (Name			Date		Location - City of		
Ore ges 1 t of F : If i		1 X Burial 2 Crema	_	Removal fro	JIII State	rematory or of		Com	o to a m . E /	E /00		ooresvi	II. NC	
Baltimore, permit. Pages I an Oppartment of Hea Important: If iter	3	4 Donation 5 Other 21. Signature Fineral Serv			GIE		Name and Ad		etery 5/	3/00				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Friedlisers	ice License			- 1							timore Ave.	
		23a Part I Enter the disease	or complic	ations that ca	aused the death	Do not enter	SCh'S	<u>Fun</u> Ivina, sı	eral Hou	me, P.	A. arrest, sh	nyattsv. lock, or heart	111e, MD 20781	
Physician 'Medical	/ /	23a: Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death												
xaminer		Immediate Cause (Final dise or condition resulting in deat		anging		5)-							-	
		or conductive stating in deal	" b	ue to (or as a	consequence of)-								
	er	Sequentially list conditions, if any, leading to immediate	D	ue to (or as a	consequence of	f):								
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760 icate icate iphy	Ĭ	IF FEMALE: 23b. Was decedent pregnant	in the		outcome of pregr			3	Ectopic pregna	2004	2	3d. Date of delive Month	ery Day Year	
68 certif	sician/M	past 12 months?		1 Live b	ant at time of de	oth _	etal death other (Specify	-	_ Ectopic pregna	aricy		MOTHER	bay real	
Box 68761 e death certificate the attending phy ed for use as the b	ysic	1 Yes 2 No 9	Unknown	9 Unkno		3 0	iller (Specify	" —			- 1			
J. B. trithe de by the ached f	Phy	Part II. Other significant co	nditions (contributing to	death but not re	esulting in the	underlying ca	ause giv	ven in Part I.	23e. Di	d tobacc	o use contribute	to the cause of death?	
, P.O. ires that the signed by	þ									1 🔲	Yes 2	✔No 3 P	obabiy 4 Unknown	
ords, w require us been si should b	ted	-								24a. W	as an		autopsy findings available	
Cords law requi	ple			_							topsy rformed1		completion of cause of	
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	Be (25. Was case referred to me examiner?	_ ⊢	ital:				10	of Death (Check					
this call	2	1 ✓ Yes 2 No	HC		npatient 2	ER/Outpatier		ــــــــــــــــــــــــــــــــــــــ		ng Home 5		dence 6 🗸 Oth	ner: Scene	
ing Ph After t		27. Manner of Death		28a. Date	of Injury , Day,Year)	28b. Time of FOUND:			at Work?	28d. Descrii Subject h		njury occurred self		
ion tendi	Certification:		Pending nvestigation	A 07		1630 hrs		1Ye	es 2 🗸 No	-1357				
ViSi or At firer d Sirect in by	ijij		Could not be	28e. Plac	e of Injury - At he	ome, farm, str	eet, factory, o	ffice bu	ilding, etc.	28f. Locatio	n (Street n, State)	and Number or	Rural Route Number, City	
Divisipital or At pital or At ours after deral Direct filled in by	ert	4 Homicide	letermined	(Specify)	Single Fan	nily Home				1001 Mt. A	iry Roa	d, Davidsonvill	e, MD	
Divisior To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the		29a. Certifier 1 Certifyin	g Physicia	n: To the bes	st of my knowled	ge, death occ	urred at the tir	me, dat	e and place, and	d due to the c	ause(s)	and manner as s	ated.	
To the Hos within 24 h To the Fun completely	Medical	one 2 Medical	Examiner:	On the basis of the contract o	of examination a tated.	nd/or investig	ation, in my o	pinion,	death occurred	at the time, da	ate and p	lace, and due to	tne cause(s)	
F 3 E 8	¥	29b. Signature and title of ce					29c. l	icense	number		290	I. Date signed (I	Month, Day, Year)	
		V 11 class	2 11	$\mathcal{U}(\mathcal{I})$				D.C.N	1.E.		Ap	oril 28, 2008		
0 (5)	- 1	20. Name and address of per	son who co	eted caus	se of death (Item	1 23a)								
CK-(3)		Laron Locke MD.			l Examiner		n Street, E	Baltim	ore, MD 212	201				
Sta	ate	31. Date filed (Month, Day, You MAY 0 2 200	ear)	32. Re	egistrar's Signatu	ure								
Regist	rar	MAT U Z 200	Ŏ,	Come	15 16	The same							_	
DHMH 17 Rev 1/20	001	00	100		-/	ORIGINA	AL							

Please Type or Print in Black Indelibje Jnk JEnsure All Copies Are Legible. Amend Item 11 G893 7/7/09 dk. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Vaudrey Bud Clinkscale Jr. 20, 2008 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Prince Georges Hyattsville St. Thomas More Facility If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F unknown 67 DC Director 10/19/1940 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show MD Prince Georges Hyattsville XXYes 2 □ No ral", or Items 23a or 28a-f sh Examiner must be notified Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20782 4922 LaSalle Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 2 If Yes, Give Year or Dates: 2 **X** No TXDNover Married 2K1 Married sBlack 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than filed within Hygiene. Northeast Market Butcher 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vaudrey B. Clinkscale is marked Ada McDaniel and 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun Julia Allen/ Sister 1609 Gales St. NE Washington, DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Riverdale Crem. May1,2008 Riverdale MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dunn&Sons 5635 Eads St. NE Washington, DC ant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final HV101C **Physician** disease or condition resulting in death) yeurs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events pue to (or as a consequence of) Examiner that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□ Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ Intauction 1 Yes 2 No 3 Probably 4 dnknown Completed Encephalopath 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate ha 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After Injury To the Hospitar ...
within 24 hours after death.
To the Funeral Director: Aft 1 Maturat 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

3altimore, Maryland 21215-0036

Box 68760,

P.O.

Division or Vital Records,

State Registrar

31. Date filed (Month, Day, Year) MAY 0 2 2008

DEVORE MB 4203 QUEONSBURY Ad HYattoTHE MB 2029 32. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APRIL 25 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 5-10-2008 George T. Denney 8:05 AM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Somerford Assisted Living Frederick Frederick If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 87 Yrs, 8. Date of Birth (Month, Day, Year) 5-28-1920 5. Social Security Number 9. Birthplace (State or Foreign Country) D Λ Min. Months Days Hours PA 579-12-2874 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No Frederick Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3230 Basford Rd PO Box 388 21755 USA 12. Was Decedent Ever in U.S. Armed Forces? 1★JYes 2□No If Yes, Give Year or Dates: ₩₩ I] 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced ΤT 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) of Engineers Architect Army Corps 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laura T. Robinson Charles V. Denney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Denney wife 3230 Basford Rd PO 388 Jefferson MD 21755 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-14-2008|Petersville, MD 4 □ Donation 5 □ Other (Specify) St. Marys Cem. 21. Signature on Funeral Serve Lice 22. Name and Address of Facility Keeney & Basford P.A. F.H 106 East Church St. Frederick, MD 21701 M01176 23a. Parta. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dreumania IWPPK Due to (or a a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Ulnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 **N**0 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No Bladder 24a. Was an

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event.

Physician

/Medical

Examiner

10a State

MD

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "recipal Exam men, and by notified at

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed attending physician and for use as the burial-trar P.O. Box 68760, Division of Vital Records,

Hospital or Attending Physician:

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun

been signed by the should be detached page 2 s Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 🗌 Yes 27. Manner of Death 1 Natural 2 Accident

3 Suicide 4 ☐ Homicide

29a. Certifier

5 Pending investigation 6 ☐ Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence

Other (Specify) 551 34F 28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

Shah 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28c. Injury at Work?

State Registrar

Trymos no 21702 Thom Conth, Day, Year) Registrar's Signatu 31. Date filed (Month, Day, 19 MAY 2008

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 0233 AM Martha Jane Day May 2, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery <u>Rockville</u> 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months | Days 1 □ M 2 🗓 F Hours Min Director 85 005-14-0233 June 8. 1922 Massachusetts Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location r 28a-f show notified at 10h County 10d Inside City Limits 1 ☐ Yes 2X No Director Maryland Montgomery Clarksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rral", or items 23a or Examiner must be r Funeral 22708 Birchcrest Lane 20871 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. Is marked other than "natural", or iter 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🗓 No Specify: þ 3 XWidowed 4 ☐ Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) 12 Print Shop Typesetter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Newton Elmer Swift, Sr. ပ Ruth Cecile Drake 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an Cindy Jo McGrew, daughter 22708 Birchcrest Lane, Clarksburg, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5/5/2008 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department of Important; if any injury or once. 4 Donation 5 Other (Specify) Upper Seneca Baptist Cemetery Germantown, Maryland 21. Signature of Juneral Service License 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, learn failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Partf. En immediate Cause (Final disease or condition resulting in death) **Physician** Gastrointestinal Hemorrhage /Medical Due to (or as a consequence of): Examiner Duodenal Mass Lesion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Hunknown Septicemia, Clostridium Difficile Colitis Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed certificate 2XNo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 70 Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No s after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Machoni D0062562 MAY 02, 2008 Murol 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAPHAVI HUBBLY NO 9901 MEDICAL CENTER DRIVE ROCK-ILLE MAKYUND 31. Date filed (Month, Day, Year) 32. Registras Signature

Registrar DHMH 17 Rev 1/2001 MAY 0

5 2008 ▶

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Year **Physician** Bertha Louise Daniels 11:33 aM May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | March 7, 1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 X F 212-22-2508 Yrs. 82 Director New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2XXNo Maryland Cecil Perryville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1571 Principio Furnace Road 21903 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 № No Specify: ģ Specify: 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Eight Years College (1-4or 5+) Personal Residence Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William C. Heath Amanda A. Schellhardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If lean 27 is any injury or other traun Ronald A. Daniels (son) P.O. Box 75, Charlestown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1- Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Principio Cemetery 05/06/08 | Perryville, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month 4□Pregnant at time of death Day Year 5 Other (specify) o 9 Unknown conditions contributing to death by not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 Probably Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 25 No ivision of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death

1

Natural

2

Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title occertifier 29d. Date signed (Month, Day, Year) D0036940 Dem 23a) (Type, Print) HARFORD MEMORIAL SOUTH UNION AVENUE, HAVRE State 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death LEWIS DAVIS 4b. City. Town, or Location of Death 4c. County of Death LANHAM

1. Decedent's Name (First, Middle, Last) 3. Time of Deuty **Physician** MARGARET /Medical 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S DOCTOR'S HOSPITAL 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 □ VF 89 Yrs. Director 414-34-8758 DEC 24 1918 WEST_VIRGINIA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 X Yes 2 No CAPITOL HEIGHTS MD PRINCE GEORGE'S 10f. Zip Code 10g. Citizen of What Country? 20743 USA 7009 HASTINGS DRIVE by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. 1 Never Married 2 Married BLACK 1 ☐ Yes 2 No if Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 6th MAID 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be WRIGHT is marked JULIA **JAMES** HUNT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 7009 HASTINGS DRIVE CAPITOL HEIGHTS, MARYLAND 20743 CURTIS 0. DAVIS/SON Baltimore 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 5 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State mportant: If Injury (4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 5/3/2008 LANDOVER, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** ANTERLIOSCIENOTIS CARDIOVASCULGA -Re125 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of attending physician and Due to (or as a consequence of): Physician/Medical as the t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Periphenal Vascular Disase 1 Yes 2 No 3 Probably 4 Unknown Completed Bilateral above knee amoutation 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☑ No Dementra 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Certification: To 6 ☐ Could not be determined 3 Suicide 4 Homicide Funerai 29a. Certifier Medical

(Check only

28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 001852 29d. Date signed (Month, Day, Year) APRIL 28 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID 4203 Queensbury Rd Hyattsville MD 20781 DEVURE 31. Date filed (Month, Day, Year)

State Registrar

MAY 0 2 2008



To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0848 02 Brenda A. Deal 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore University of Mayland Medical Certer If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 02/15/1958 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F 577-80-0042 Cheverly, Md. Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1√Yes 2 No Md_{-} Director Prince George's Capitol Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1114 Iago Avenue 20743 U.S.A. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. 4 yrs. Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If item 27 is marked other the any injury or other traumatic event, the once. Computer Specialist/IRS U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James L. Thompson Shirley Deal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tommy Peterson/Son 1114 Iago Avenue, Capitol Hgts., Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem. Park 05/08/08 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility on & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee aug JARO Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Malignancy **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2⊠No signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Hyperconjulable Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed death? certificate 2 No 1☐ Yes 2 No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🕱 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Dunpatient 2 this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Certification: Attending 5 ☐ Pending investigation 1 🗷 Natural 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: A death. 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAY 0 5 2008

Minshan Leo Tsay

DHMH 17 Rev 1/2001

within 24

Medical Resident

32. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

22 South Greene street Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

5-2-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) April **Physician** 29^{y} 2008 07:10 PM Carl M. Ercoli /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/14/1919 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Hours Washington, D.C. 578-05-8413 89 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show 1 Yes 2 No r than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified Director Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21037 United States 1509 Fullerton Road Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Paint Contractor Painting 8 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luigi Ercoli Grazziello Maggi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Linda Krimstein/Daughter 2219 S. Bentley Ave., Los Angeles, CA 90064 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/01/2008 | Edgewater, Maryland Kalas Crematory 21. Signatura service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home MAR 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 mon 1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f Division or Vital Records, P.O. 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autops certificate 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Frioutpatient 3 DOA 1 ☐ Yes 2 1 Inpatient within 24 hours after death. To the Funeral Director; After this completely filled in by the funeral director. 27. Manner of Deat 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident (Month, Day Year) or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)
MAY 0 2 2008

30. Name and address of person who completed cause

32. Registrar's Signature

of death (Item 23a) (Type, Print

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month May 01 2008 3:50 p M George Lewis Erb 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Carroll Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Hours 152 M 2 □ F Yrs. Feb 26 1929 MD 79 216-22-8745 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Carroll Westminster 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 USA 402 Barnes Avenue 12. Was Decedent Ever in U.S. Armed Forces? 105 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1951 1953 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto Parts Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Reaver unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Barnes Avenue Westminster, MD 21157 Betty Erb/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5/6/2008 Burial 2 ☐ Cremation 3 ☐ Removal from State Manchester Baptist Chi Cem Manchester, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cancer tastan 2480x disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 **-** No

Physician /Medical Examiner Examine

attending physician and for use as the burial-tran

signed by t I be detach

has

al or Attending P

Director ,

To the Hospital or Atte within 24 hours after de:

To the Funeral Directo completely filled in by the complete of the complete

MJL

PALIFOI

Physician/Medical

þ

Completed

Be

Certification:

Medical

State Registrar

certificate be executed

Box 68760,

Division or Vital Records, P.O.

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

Medical

traumatic event, the

nd Mental Hygiene. marked other than

S

Department of Health ar Important: If item 27 is 1

d 2 should be fi th and Mental H

within 72 hours after death

Baltimore, Maryland 21215-0036

Director

Funeral

by

Completed

Be

Sequentially list conditions, if a y, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 5 ☐ Pending investigation

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Westminiter MO 2/157

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

27. Manner of Death

1 ☑Naturai

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

oel,

6 ☐ Could not be

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 291 Stoner

31. Date filed (Month, Day, Year)

2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** 610 AM George A. Enuton 05 05 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Coastal Hospice At Salisbury The Lake Wicomico If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F 2/22/1936 577-46-2703 72 Washington, DC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location t0a State 10d. Inside City Limits 1 ☐ Yes 2 XNo Director MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11619 Windward Dr. 21842 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify: 3 ☐ Widowed 4 ☐ Divorced white Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Communications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ignacio Enutan Betty Alpert P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Franklin / finace 11619 Windward Dr., Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 5/8/2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, MD 21811 Part1. Enter the disease shock, or heart failure. polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARCINOWA **Physician** OF TONSILLAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in resolution cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-trans Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2∐No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes → No 24a Was an certificate has be irector, page 2 s autopsy 1∐ Yes 2 🖵 🛱 b 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time:of 28d. Describe how injury occurred Medical Certification: 1 Natural

2 ☐ Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Physician; The law requires that the death certificate be executed attending physician for use as the buria signed by t After t Hospital or Attending n 24 hours after death.

ne Funeral Director: Al within 24

> State Registrar

GHUIAM WARS 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier (Check only /

4 ☐ Homicide

6 Could not be determined

P.O BOX 1733 SACISBURY UND 21802 HOSPICZ CONSTAL 32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00058410

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9:40 8 pril 2008 Rosa Lee Easley 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months 1 □ M 2 □ TF 577-60-8862 61 Sept 3, 1946 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10b. County 11 Yes 2 No Maryland Prince George's District Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2738 Crestwick Place 20747 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White etc. African 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 years College (1-4or 5+) Nurse Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas A. Queen Mattie Toogood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George E. Easley - Husband 2738 Crestwick Pl District Heights, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem. Park May 2, 2008 Landover, MD 4☐Donation 5☐Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sign dure of Fun and Service License 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acreus Due to (or as a conseque Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Unknown Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 II No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) spital: 13 Inpatient 2 | 28a. Date of Injury (Month, Day Year) 1 ☐ Yes 2 ER/Outpatient 3 DOA

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

burial-trar the attending pl ed by the a has certificate director, After after death filled in by Hospital or n 24 hours af

Physician

/Medical

Examiner

Funeral

Director

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"natural", or items dical Examiner mu

traumatic event, the Medical

Department of Health a Important: If item 27 Is any injury or other trauonce.

Physician

/Medical

Examiner

than

and Mental Hygie Is marked other to

death

filed within 72 hours after

Pages 1 and 2 should be

altimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

2

Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

within 24 Registrar

State

30. Name al Mer s of person who ser 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3001 Hospital Dr. 14-401, cheverly my 20785 Ni 32. Registrar's Signatu

and manner stated.

MAY 0 2 2008

5 ☐ Pending investigation

6 □ Could not be

ed cause of death (Item 23a) (Type, Print)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

D0057649

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 2008 **Physician** Apri1 26, 7:00 A. [™] Chaluey Enos /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Rethesda If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min 1 □ M 2 X F Thailand Feb. Director 129-54-1076 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f sh idicai Examiner must be notified 1 ☐Yes 2 No Silver Spring Director Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910 Thailand 8914 Pennsylvania Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ê No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify. Specify: þ 3 Widowed 4 □ Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Food Preparer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8914 Pennsylvania Ave; Silver Spring MD 20910 Padungdej Nitayavardhana 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/29/2008 Everly Crematory Alexandria, VA injury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eureral Service Licensee 22. Name and Address of Facility Everly Wheatley 1500 W Braddock Rd Alexandria VA mo145 23a. Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pneumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Munknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) **XX**No ို 1 🔲 Yes 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification:

certificate be execute y physician and as the burial-trans attending pl certificate Hospital or Attending Physician: 24 hours after death. thin 24 hours after control of the Funeral Director; A

Records, P.O.

Vital

Division or

or 28a-f show

within 72 hours after death

Pages 1 and 2 should be file ment of Health and Mental H ant: If item 27 is marked oth

permit. Pages 1 Department of H Important: If ite

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Baltimore, Maryland 21215-0036

ENOS, CHAL completely the 0 State Registrar

and manner stated. 29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

29c. License number

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

leted cause of death (Item 23a) (Type, Print)

86\0 \int 1d Georgetown Road Washington DC 20814 Natasha Haag

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)
MAY 0 5 2008

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Hornicide

32. Registrar's Signat

Medical

To the Hospital or Attending Physician: within 24 hours after death. To the Funeral

DHMH 17 Rev 1/2001 OCME 2006

Registrar

State

29b. Signature and title of certified

31. Date filed (Month, Day, Year)
MAY 1 7 2008

MAY

Patricia Aronica-Pollak MD.

Assistant Medical Examiner

32. Registrar's Şignature

ah

30. Name and address of person who completed cause of death (Item 23a)

OCME

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

May 8, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended, #23b, **1**- State MD, 04/25/2008, TLS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Vernia Lutrica Flood 2008 /Medical 23 9:27 AM4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Talbot Genesis HealthCare - The Pines Easton If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Min. 1□M 2 F Months Hours Director 044-20-1508 84 01-08-1924 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits 10b. County 28a-f show 1 ☐ Yes 2 ☐ No notified Director Md. Talbot Trappe 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Department of Health and Mental Hygiene. Important: for items 23a or Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event. 6240 Old Trappe Road 21673 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 22 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: þ Specify: 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) 9 <u>Homemaker</u> Private Families 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Noah Frazier Eary Etta Murray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Chamber / Daughter 29875 Dutchman's Ln., Easton, Md. 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State Md. Veterans Cem. 04-28-08 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, Maryland of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover St., Easton, Maryland 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Moundial M. **Physician** m mutes disease or condition resulting in death) /Medical Due to r as a consequence of): Examiner occlusion nonutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a ny sequence of): Examiner death certificate be executed burial-trar Due to (or as a consequence Box 68760, physician Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate | or Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division or Attending 5 ☐ Pending investigation ↑ Natural 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide

Hospital hours

24

DHMH 17 Rev 1/2001

Medical

State

Registrar

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

610

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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APR 2 5 2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DUTCHMANS

29c. License number

LANK

29d. Date signed (Month, Day, Year)

Linda Darlene Foss 08-03509 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Death Month D. May 7, 2008 Day 1931 hrs **Medical Examiner** Linda Darlene Foss 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Prince George's Route 301 and Frank Tippett Road Brandywine 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Min oreign Months Davs Hours Director 219 56 1686 Country) 1 M 2 XF 58 Yrs Nov 4 MD Usual Residence of Decedent 10d, Inside City Limits 10a, State 10b. County 10c. City, Town or Location Yes 2 28a-f show MD Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoor or other traumatic event, the Medical Examiner must be notified at once. Anne Arundel Lothian Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 84 E Street 20711 United States Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 2XX No 3 Widowed f Yes. Give Year Yes 2 XXNo specify: Δ Divorced Specify White \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Cashier Grocery 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Walter Foss Be Beulah Rickert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosena Bell (Executrix) 5476 Morris Ave, Suitland. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State ✓ dlb.

Permit. Pab.
Department of .
vportant: If i' crematory or other place) Burial 2 X Cremation 3 Removal from State Lee Crematory May 13, 2008 Donation 5 Other Space Clinton. 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral, ou Alexandria Ferry Road, Clinton, MD 20735 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a, Part I, Enter the Physician failure. List outy he cause on each line. Between Onset and /Medical Death Immediate Cause (Final disease or condition resulting in death) Thermal injuries and smoke inhalation xamine Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical X UNPENDED #MENDED attending physician or use as the burial &28a-f. perME.g879 5/22/08 TT The law requires that the death certificate be Records, P.O. Box 68760, 23d. Date of delivery SE EEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) cate has been signed by the att page 2 should be detached for 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) **Division of Vital** funeral director. Be examiner? Other₄ DOA Nursing Home 5 Residence 6 ✔ Other: Scene After this Inpatient 2 ER/Outpatient 3 ۵ 1 V Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred Certification: driver in auto/fixed object collision 1 Natural I hours after death.
uneral Director: A
ly filled in by the fu Yes 2 X No Pending 5/7/2008 7:20 pm with subsequent fire 2X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 or Town, State) MD : 301 & Frank Tippett Rd Brandywine Could not be Suicide determined (Specify) Rt 4 Homicide road 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hospital or Attending Physician: within 24 hours at To the Funeral I

> Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day Year) 008 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

- IMID.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 8, 2008

Medical

State Registra

29b. Signature and title of certifier

Ion me

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** APRIL 24,2008 0603AM ^M JUDY ANN GETSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT EASTON MEMORIAL HOSPITAL AT EASTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
JULY 9,1962 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 X 45 MARYLAND Director 212-78-5824 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2 No notified Director EASTON TALBOT MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 27 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be n 21601 USA 9674 UNIONVILLE ROAD items 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No Specify: WHITE Completed by 3 ☐ Widowed 4 M Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental F GLADYS HOWELL IRVIN SEIGLER, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra 9674 UNIONVILLE ROAD, EASTON, MD 21601 JULIE CUSTODIO/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) SPRING HILL CEMETERY 4/28/2008 EASTON, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA C.1.5% 1 oseph m. USPONSK:

Physician /Medical Examiner

and 2 should be filed within 72 hours after death vealth and Mental Hygiene.

Pages 1 ment of F

Baltimore, Maryland 21215-0036

requires that the death certificate be executed burial-transi attending physician for use as the buria

Box 68760,

P.0.

Division or Vital Records,

or Attending

Exami Physician/Medical þ

After this certificate has death. the Director: filled in by within 24 hours at To the Funeral D

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 25. Was case referred to medica examiner? Be 1 ☐ Yes 2 💢 No Certification: To 27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 No

Truct

acheobronchitis

navy

6 Could not be determined

4□Pregnant at time of death 9☐Unknown

Due to (or as a consequence of)

Due to (or a seconsequence of).

etastate

3 □Ectopic pregnancy 5 Other (specify)

200 S. HARRISON ST., EASTON, MD 21601

23d. Date of delivery Month Day

Approximate Interval Between Onset and Death

day

Year

2008

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy perform

26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🖄 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 5 Pending investigation

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 1 Yes 2 🗆 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Infection

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 29b. Signature and title of certifier 47232

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 Suite 10

State Registrar

Medical

31. Date filed (Month, Day, Year)

APR 2 8 2008 Registrar's Signature

and manner stated.

ORIGINAL

44/VA

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

MAY

2008

Heorge C. Wills III. D. D41365 May 3, 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Seovge E. Wills III. 3900 Loch Raven Boulevard, Bathingue,

31. Date filed (Month, Day Year)

29d. Date signed (Month, Day, Year)

			Fiease	State of Marylar					•	ole.	10007
			1 - For State Registrar	oraro or maryiar		rtificate of			Reg. No.	UU	10441
	O !ii		1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medio		Tyrone	W	(ray	Sr.	April	29, 2	800	2055 p ^M
1	Examir	er 🦠	4a. Facility Name (If not institution, give				or Location of Death		4c. County		
	26 g	198	Holy Cross Hos 5. Social Security Number 6. S	•	last hirthday)	Silve If Under 1 Year	er Sprin	O Date of Birth	-	gome	_
	Funeral Director			ex 7. Age (In yrs	. iast birtriday) Yrs.	Months Days		04/15	/, Year) /1956	Cou Mar	place (State or Foreign intry) cvland
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	arylar show d at	-	10a. State 10b. County		ity, Town or Lo						10d. Inside City Limits 1 X Yes 2 No
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	ns 23	lera	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.		639 Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No-	USA 14. Ra	ce - Ameri	can Indian,
9	after or ite	Fü	1 ☐ Never Married 2 ★ Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		If Yes, specify Cut 1 ☐ Yes 2 ② No		o Rican, etc.)		ck, White,	
03	ours ours	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		TLIYES ZLAJNO	Бресіту:			y:BLA	
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Baltimore,	permit. Pages 1 end Department of Health Important: if item 27 any injury or other tr once.		4 □ Donation 5 □ Other (Specify 21. Signature 🏕 fune real Service Licery			ection 2. Name and Addr	5/6,	dams Fu			Maryland
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	To the Hospital or Atteni within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	29a. Certifier 1 **Certifying Ph (Check only 2 ** Medical Exar	nysician: To the best of my kr miner: On the basis of examir and manner stated.	nowledge, dea nation and/or i	th occurred at the nvestigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and n date and place	nanner as , and due	stated. to the cause(s)
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ſ			30. Name and address of person who	completed cause of death (Ite	em 23a) (Type,	Print)	, , , ,		,1,	1 5	0
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Registrar

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2008

			For State Registrar	State of Mary	yiand /	•	rtment of F tificate of		-	giene Reg. No	0000	16229
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	Director		182-30-8221 Usual Residence of Decedent	□ M 2 □ X € 6 9)	Yrs.	Months Days	Hours Min	March	26,) Cou	ennsylvania
	yland now at		10a. State 10b. County	10	0c. City, To	own or Loc	ation					10d. Inside City Limits
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	vith th	Dire	10e. Street and Number	Б.			10f. Zip Code			10g. Ci	tizen of What Cou	intry?
	eath is 23am	eral	245 Winding Oak	12. Was Decedent Eve	er in U.S.	13. V	217		Snecify Yes or No)-	14. Race - Ameri	ican Indian,
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tr of Health and Mental Hygiene. If them 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			vas Decedent of F Yes, specify Cub ☐ Yes 2☐ X lo		rto Rican, etc.)		Black, White Specify:	
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Σ	1 and 2 Health eem 27 is		Walter J. Gostow								nd, Md.	
ore	ges 1 If Iten or oth		20a. Method of Disposition 1XXX urial 2 Cremation 3 C	Removal from State			sition (Name of natory or other pla	1	Date	20c. L	ocation - City or 1	own, State
ti.	t. Pages tment of I tant: If Ite		4 □ Donation 5 □ Other (Specif	y)	Rest		en Ceme		/2/08		gerstow	
Bal	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other		21. Signature of Funeral Service Licer	MM.	. (<i>V</i>	Name and Addre	16			NERAL I	
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	/Medical		disease or condition resulting in death)	a. Due to or as a c	onsequen	ce of):						
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89	tificate g phy: as the	edical		S. 0.								
Вох	death certific attending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf 1 ☐ Live birth 2 [Ectopic pregnanc	v			23d. Date of deli	,
П	Attending Physician: The law requires that the death cer rdeath. rdeath. After this certificate has been signed by the attending the funeral director, page 2 should be detached for use	sicis	in the past 12 months? 1 ☐ Yes 2 No	4□Pregnant at tin			Other (specify) _	,			Month	Day Year
Vital Records, P.O.	hat th d by t letach	Phy	9 ☐ Unknown Part II. Other significant conditions of	contributing to death but r	not resultin	a in the fun	derlying cause div	en in Part I	23e Did	tobacco	use contribute to	the cause of death?
ds,	signe signe d be o	d by	HORNIC HURACCA	ONIC ROSPIE		- /	Jupo .	TOTAL TOTAL			2 No 3 Pro	. 1
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Division or	Ing Pl		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Y		b. Time of Injury	28c. Inju Wo		28d. Describe	how inju	ury occurred	
S	ttend feath. ttor / the fi	cati	2 Accident investigation 3 Suicide 6 Could not be	I	- At hamo	form etre		Yes 2 □ No	Opt Legation	Ctroot	and Alumbar or Du	val Pauta Mumbar
		Certification:	4 Homicide determined	building, etc. (Specify)	, 181111, 3111	eet, lactory, office		City or To			ral Route Number,
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	Vithi Vithi To th	ž	29b. Signature and title of certifier				29c. Licens	se number	,	29d. Da	ate signed (Month	n, Day, Year)
			• 111115 Qd	M			1000	307/	/		4/29/	108
05	H-8	5	30. Name and address of person who MARL BALON, &	b E. ONT	h (Item 23	(Type, I	He got	WN, MC	2/120		/ /	
ŀ	Sta Registi		31. Date filed (Month, Day, Year) APR 2 9 2	32. Rogistrar's	Signature							
DUL	IH 17 Pov 1/2	001		The Mary and Mary and		-		**-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month

3. Time of Death

1 - For State Registrar **Physician** /Med Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Iujury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

SH-5

Sta Registrar

ian cal	Natalie Margarete Gili	perto-Peter	^ s	ANCI)	Di di	Year	1926	PM
ner	4a. Facility Name (If not institution, give street and number,)	4b. City, Town, or Location	of Death	4c. County	of Death		
2	Washington County Hospita		Hagerstow				ngton	
	1 1 M 2 X F	ge (In yrs. last birthday Yrs.	If Under 1 Year If Under 1 Months Days Hours			Count		oreign
	Usual Residence of Decedent	46 113.		Nov.26	,1961	Dela	ware	
ř	10a. State 10b. County	10c. City, Town or L				10	d. Inside City L	
ect	Maryland Washington 10e. Street and Number	St	James 10f. Zip Code		10g. Citizen of	Mh at Count		
ä					rog. Citizen or		ıy:	
eral	9115 Lydia Lane 11. Marital Status 12. Was Decedent	Ever in U.S. 13	21781 Was Decedent of Hispanic O	rigin? (Specify Yes or No	14. Rac	USA ce - America	n Indian,	
들	Armed Forces'	?	If Yes, specify Cuban, Mexic	an, Puerto Rican, etc.)	Blad	ck, White, e	tc.	
Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	See a see a see a see a see a see a see a see a see a see a see a see a see a see a see a see a see a see a se	1 ☐ Yes 🏋No Specify	y:	Specif	y: W	hite	
ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occupation e kind of work done during mo	nst of working	16b. Kind of B	usiness/Indi	ustry	
햩	Elementary/Secondary (0-12) College (1-4or	life.	DO NOT use retired)	, or or norming				
ပြ	12		Housewife	hada Nama /Finak Adiddla		Home		
a	17. Father's Name (First, Middle, Last)		4	her's Name <i>(First, Middle,</i>		,		
မ	Giuseppe Carmelo Giliber 19a. Informant's Name/Relationship (Type. Print)		ling Address (Street and Num.	sula Margar			0-4-1	
	Robert Peters - Husband	i	o Lydia Lane					
-	20a. Method of Disposition	20b. Place of Disc	position (Name of	Date Date	20c. Location			
	1 ☐ Burial 2XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (<i>Specify</i>)		ematory or other place) rg Crematory	April 29 200)8 Smi+h	nehura	Mary	land
١.	21. Signature of Funeral Service Licensee		soummed Fourment and		70 311111	isour g	, indi y i	and
	() College () Share		25 S. Conococh		lliamsp	ort,	MD 2179	 5
	23a. P Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do not en	nter the mode of dying, such a	as cardiac or respiratory a	rest,	1	Approximate Interval Between	en
	Immediate Cause (Final disease or condition	met c	DINCON (1	metact.	atic) ,	Onset and Dea	ith J
	resulting in death)	s a consequence of):	ancer (reiusi	2416	-	os ma	2 n FV
	Sequentially list conditions b.							
ner		s a consequence of):						
am	Cause (Disease or injury that initiated events resulting in death) Last					$-\!\!+\!\!$		
<u>E</u>	Due to (or as	s a consequence of):						
gi	d							-
sician/Medical Examiner	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant				23d. Da	ate of deliver	v	
icia	in the past 12 months? 1 ☐ Live birth		☐Ectopic pregnancy ☐ Other (specify)		Me	onth I	Day Yea	ır
Phys	9 ☐ Unknown 9 ☐ Unknown							
S P	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given in Part	t I. 23e. Did to	obacco use con	tribute to the	e cause of deat	th?
ed					res 2 No	3 Proba	ably 4 ∐Unk	nown
Completed by				24a. Was		Were autop	sy findings ava	ailable se of
Ę				perfo 1⊟ Yes	rmed? 2.23.No	death?	2	
Be (25. Was case referred to medical examiner?			ce of Death (Check only o	ne)			
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io io	27. Manner of Death 28a. Date of Inj		of 28c. Injury at Work? M 1 □ Yes 2 [now injury occu	rred		
icat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of in	njury - At home, farm, s			Street and Num	beror Rumai	Route Numbe	r
ertif	4 Homicide determined 20e. Flace of it building, €	etc. (Specify)	, ,,	City or Tov		50, 0, 7,4,4,	710410 11417150	
a C	29a. Certifier Decertifying Physician: To the bes	t of my knowledge, dea	ath occurred at the time, date	and place, and due to the	cause(s) and m	nanner as st	ated.	
Medical Certification:	(Check only 2 Medical Examiner: On the basis and manner s		investigation, in my opinion, d	eath occurred at the time,	date and place	, and due to	the cause(s)	
Ž	29b. Signature and title of certifier	1	29c. License number	r	29d. Date signe	ed (Month, I	Day, Year)	
	Had Han	ndo	it 046	473.	ARI	1 2	1, 200	SC
	30. Name and address of person who completed cause of	death (Item 23a) (Type	e, Print)	il.	,		1 N.	
	Tlind Hamdan, M	001130	DPAL CT.	Hagers	town,	M	2116	t-0
ate rar	31. Date filed (Monappe 32) 2008 32. R	tran's Signature	Acres 14	7	,			
2001								

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician:

filled in within 24 hours at To the Funeral C completely filled i Medical State Registrar

30. Name and address of person who completed cause 31. Date filed (Month, Day, Year) MAY 0 2 2008

29b. Signature and title of certifier

29a. Certifier

6060 ATLINGTON BLUD FALLS CHURON UA

of death (Item 23a) (Type, Print)

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** CARLTON ALEXANDER HARPER 2008 0520:03 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner ALLEGANY 71 FROST VILLAGE FROSTBURG If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 XM 2 ☐ F Director 12-14-1937 216-38-1271 70 MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be a series once. 10d. Inside City Limits 10a. State 10b County 10c, City, Town or Location 1 X Yes 2 □ No Director ALLEGANY FROSTBURG 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 71 FROST VILLAGE UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: BLACK ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HEAVY EQUIPMENT OPERATOR CONSTRUCTION 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LUCIUS HARPER မ PRICILLA WASHINGTON HARPER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALLEN HARPER SON 108 FAWN TRAIL JACKSONVILLE, NC 28540 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State FROSTBURG MEM PARK 05-17-2008 FROSTBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOWERS FUNERAL HOME, P.A. Sowers MOOS 47 60 W. MAIN STREET FROSTBURG, MD 21532 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician news disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** vronn Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical the I attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≨</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Onknown nis certificate has been s director, page 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No 1 ☐ Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Amesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760, n 24 hours after death.

le Funeral Director: Af
bletely filled in by the fur within 24 ho

To the Fune

completely f the

29a. Certifier

(Check only one)

29b. Signature and title of certifie

Medical

Name and address of person who completed cause of death (Item 23a) (Type, Print) Broadwa lAn Day, Year) 1 9 2008 82. Registrar's Signature State Registrar

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

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State

Registra

31. Date filed (Month, Day, Year)

MAY 1 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St., Hagerstown, MD 21740

32. Registrar's Signature

			For State Registrar	State	of Marylan		artment of H rtificate of I				2.0		
N.			Registrar 1. Decedent's Name (First, Middle	e Last)		Cei	lilicate of t	Dealli	2. Date of Dea	Reg. No.	98	3. Time of Death	٦
4.6	Physicia			,					Month	Day	Year	8:55 A ^M	
100	/Medic Examin		Guy Irvin Hurle 4a. Facility Name (If not institution		umber)		4b. City, Town, or	Location of Deal	May 1,	4c. County	of Death	0.33 A	\forall
	Examin	eı	Washington Adve				Takoma P			Montg	omers	7	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs		h		ace (State or Foreign	1
	Director		215-26-8767	1 X M 2□ F	78	Yrs.	Months Days	Hours Min	Dec. 20	1929	Mary1	and	
	p ,		Usual Residence of Decedent 10a. State 10b. County		100 Cit	y, Town or Lo	ontion				10	Od. Inside City Limits	7
	anyla shov	ž	10a. State 10b. County		100. 01	y, rowiroi Lo	cation					1 ☐ Yes 2 🕱 No	
	he M 28a-f otifie	Director	Maryland Montgo	mery	Dama	scus	10f Zin Code			10g. Citizen of W	What Count		4
	a or be n	ä	10e. Street and Number	_			10f. Zip Code				viiat Couri	uy:	
	eath ns 23 must	era	26131 Purdum Ro		cedent Ever in U	.S. 13.1	20871 Was Decedent of H	ispanic Origin? (S		USA 14. Race	e - America	an Indian,	+
10	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	Funeral	1 ☐ Never Married 2 💢 Marr	ied Armed F	Forces?		If Yes, specify Cuba	an, Mexican, Pue	rto Rican, etc.)		k, White, e	etc.	
93	urs a	Completed by	3 ☐ Widowed 4 ☐ Divorced	If Yes, C Year or	ive		1∐Yes 2 X No	Specify:		Specify	Whit	e	
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2	led w lygiel her tl ht, th	Ŝ	12 17. Father's Name (<i>First, Middle,</i>	/ ant)		Servic	e Manage		me (First, Middle,			ealership	_
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be									<i>ie)</i>		1
Ž	hould d Me mark matic	유	Guy Lansdale Hu 19a. Informant's Name/Relations			19b. Mailir	ng Address (Street		sephine		State Zio	Code)	-
<u>≅</u>	nd 2 s Ith ar 27 Is 1 trau		Deborah Hurley,		r		Oak Drv				2087	_	
ā,	f Hearlitem		20a. Method of Disposition		20b. F		sition (Name of matory or other place		Date	20c. Location -	City or To	wn, State	-
E O	Page ent o nt: If		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		n State		ew Cemete	1	2008	Damascu	s. Ma	rvland	
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m	Depar Impor any Ir		Hanh	1. Du	an		401 Ridge					20872	
	*		23a. Part Enter he disease, or shock, he rt failure. List	complications that	caused the deat	th. Do not ent	ter the mode of dyir	ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between	
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	/Medical		resulting in death)	Due t	o (or as a consec	quence of):	17.0		-	- 3			_
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	ed sit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Duet	o (or as a consec	quence or):					-		
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8760,	cate be executed physician and the burial-transit	E E			`	•							
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Вох	death certific e attending p d for use as	2	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregn		7			23d. Da	te of delive	ery	
	death e atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre	e birth 2□Feta gnant at time of d		⊒Ectopic pregnanc ⊒ Other (specify) _	у		Mo	onth	Day Year	
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ord	w requires been sign should be	ed	End Stage	Lengt	Disate	<u>. </u>			. 10	Yes 2⊡No	3 ☐ Prob	ably 4 □Unknown	
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Division or Vital Records,	di is	은	1 ☐ Yes 2 ☐ No 27. Manner of Death		Inpatient 2	ER/Outpatier	IL SU DOA		Home 5 ☐ Resi			y)	_
uc	ding In.	ion	1 ☑ Natural 5 ☐ Pendir	ng (Ma	onth, Day Year)	Injury	Wor	rk? Yes 2∐No	Zou. Describe	how injury occur	reu		
Si	Attending r death. ector: After by the fune	icat	3 Suicide 6 Could	not be	ce of injury - At h	lome, farm, st	reet, factory, office	103 2 100	28f. Location (Street and Numb	ber or Rura	I Route Number,	_
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	lospital hours a uneral [29a. Certifier 1 Certifyli	ng Physician: To t	he best of my kn	owledge, deat	th occurred at the ti	me, date and pla	ce, and due to the	cause(s) and m	anner as s	tated.	-
	T 4 T %	Medical	one)	and m	basis of examin anner stated.	adon and/or ir	nvestigation, in my		curred at the time,	uate and place,	and due to	une cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifie	-	, /	7	29c. Licens			29d. Date signe			
			Stanle	nell	rehus	_	1001	225		MAY	1,2	005	
	10		30. Name and address of person	/	use of death (Ite	m 23a) (Type,	Print) Deen		10 Die	Te -11	M . 1	7. 8.	
			31. Date filed (Month, Day, Year)	EVORE	Registrate Sign	2030	A reem	sh way k	d 7744	13 all 6	MA	10/07	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death **Physician** Thomas Eugene Hiles 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 09/12/1956 Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthdav) **Funeral** Months Days Hours 1 M 2 □ F 214-36-8702 51 Director MD Usual Residence of Decedent a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington MD Hagerstown 1XYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or?
ary or other traumatic event, the Medical Examiner must be not some than than must be not be the staminer must be not be the staminer must be not be the staminer must be not be the staminer must be not be the staminer must be not be not staminer must be not be not staminer must be not staminer must be not staminer must be not staminer must be not staminer. 12 S. Walnut Street 21740 US by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 Maj If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Lee Hiles Maude Ivy Shank ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 79 Madison Ave., Hagerstown, MD 21740 Ronald L. Miley / Pers Rep 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Smithsburg Crematory 04/30/2008 Smithsburg, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardina /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation nours after death.

neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

To the State Registrar

DHMH 17 Rev 1/2001

A102.

29c. License number

DW57285

Hogerstown.

29d. Date signed (Month, Day, Year) 4 28 2008

and manner stated.

MAD

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

and title of certified

APR 29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** April 29, 2008 3:48 A. M Jean Agnes Holmes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Wash., D.C. Days 06420/1937 1 □ M 578-52-0130 70 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c, City, Town or Location 10b. County 23a or 28a-f show Examiner must be notified at Washington 1 ☐ Yes 2X No D.C. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2236 16th St., N.E. 20018 U.S.A. death v Funeral 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 No Black Specify Specify. þ 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Secretary/Office Administrator U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injuy or other traumatic event once. Be Joseph Newman Margaret Robinson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2236 16th St., N.E., Washington, D.C. Joseph Holmes/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc. 05/06/08Beltsville, Maryland 21. Signature of Funeral Service License 22. Name for \$4 Washington & Sons Co., Inc. Jany W. rall 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hen monig **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner epsis Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐Ectopic pregnancy Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed; this certificate 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one examiner? 1 Xres 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient မှ 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Matura! 5 Pending investigation within 24 hours after uses...

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 30,2008

State Registrar

James K. Lightfoot, M.D. 7600 Carroll Avenue, Takoma Park, Maryland 20912 31. Date filed (Month, Day, Year) MAY 0 2 2008

32. Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008

		1- For State Certification Cer	ficate of Death	Reg. No.	
Physici	an/	Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death
leuical Exami	ner	JAMIE C. HEARD		April 27, 2008	1208 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		
		1000 Hilltop Circle	Catonsville	Baltimore Co	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las		- \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	an
Director		462-81-1795 1≥M 2 F 21	Yrs. Months Days Hours Min.	10-22-1986 c	ountry) Texas
	- F	Usual Residence of Decedent		110 22 1900 1	
any	-		own or Location		10d. Inside City Limits
* *		Maryland Prince George's	Suitland		1 🔆 Yes 2 No
Maryland 28a-f show 1 at once.	윉	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	untry?
he M or 2	Director	4662 Lamar Avenue	20746	USA	·
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.		11. Manital Status 12. Was Decedent Ever in U.S	. 13. Was Decedent of Hispanic Dingin? (S	pecify Yes or No- 14. Race - Ame	erican Indian, Black,
eath v item	Funeral	1 **Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.	
		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:	Specify: B1	ack
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	d b	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of	work done 16b. Kind of Business	s/Industry
7 3 -	e e	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DD NDT use ret	ired)	System
136 thin re. than than	du	12th +03	Student	Baltimore	Co. School
5-0036 led within 7 Hygiene. I other than	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Maiden Surname)	
	Be	Robert Heard	Joann H	Brooks	
2121 Ould be fill J Mental Is marked	10	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	Rural Route Number, City or Town, Sta	te, Zip Code)
MD d 2 sho lth and n 27 is		Robert Heard/father	4662 Lamar Avenue Su		
e, h I and Health Fitem			lace of Disposition (Name of cemetery, ematory or other place)	Date 20c. Location - City	or Town, State
imore, MD 2121 Pages I and 2 should be fi nent of Health and Memtal iant: If item 27 is marked or other traumatic event,		Dinal 2 Cremation 3 Removal from State	erdale Pk Crematory	-05-08 Riverdale	, Maryland
altimore, permit, Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee M0 124.		7	, ridi y idild
Imp Dep		Tark A. L. J. LUD	Cedar Hill FH 4111	. PA Ave. Suitland	, MD 20746
nysician		23a. Part I. Enter the disease, or complications that caused the death.			Approximate Interval Between Dnset and
/Medical		failure. List only one cause on each line. Myocarditi	S		Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of			
		Sequentially list conditions, b			
	ner	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause):		
	Examiner	(Disease or injury that initiated events resulting in death) Last):	<u> </u>	
cecuted and - transit		d.			
760, icate be executed physician and the burial - transi	/Medical	X UNPENDED AMENDED	er MEO G-880 6/16/08 reb		
760, cate be exe physician a	Jed	# 23d & 2/ pe	er MED G-880 6/16/08 Feb	23d. Date of deliv	rery
Box 68760, seath certificate by the attending physic of for use as the bured for use as the bure	J/n	23h Was decedent pregnant in the	2 Fetal death 3 Ectopic pregr	nancy Month	Day Year
Sox 68 leath certifi e attending for use as t	Physician	4 Pregnant at time of dea	ath 5 Other (Specify)		
Bc e dea the a		1 Yes 2 No 9 Unknown 9 Unknown		23e. Did tobacco use contribute	to the course of death?
, P.O. ires that the signed by the detached	by P	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	1 Yes 2 No 3 F	
ires t r sign d be c	b L				
ords, w requir is been s should	let			autopsy prior	autopsy findings available to completion of cause of
ecc he lav nte ha	_			performed? death	
tal Recian: The certificate ector, page	Ü	25. Was case referred to medical	26.Place of Death (Chec	k only one)	
Vital Rechysician: The lathis certificate by this certificate by I director, page	o Be	examiner? 1 • Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other'4 Nurs	sing Home 5 Residence 6 🗸 Of	ther: Scene
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by inneral director, page 2 should be detach	5	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
on ath. he fu	Ę	1 X Natural 5 Pending	1 Yes 2 No		
Division tal or Attendia is after death. al Director: A led in by the fu	lig	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At he	ome, farm, street, factory, office building, etc.	28f. Location (Street and Number or	Rural Route Number, City
Div ital or ral Div	Certification	4 Homicide determined (Specify)		or Town, State)	
Hospi 44 hou Fune ely fi	<u>۾</u>	29a Certifier	ge, death occurred at the time, date and place, a	nd due to the cause(s) and manner as s	stated.
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certificate hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medical Examiner: On the basis of examination a	nd/or investigation, in my opinion, death occurred	d at the time, date and place, and due to	o the cause(s)
F W F	Me	29b Signature and title of certifier	29c. License number	29d. Date signed ((Month, Day, Year)
		(hlanne)	O.C.M.E.	April 28, 2008	
P.	h	30. Name and address of person who completed cause of death (Item	23a)		
i		Zabiullah Ali, M.D. Assistant Medical Examiner		21201	
:5	ilata	A 17 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -		OCME	
Rani		MAY O 7 YOUR		OUNE	

Demetrius Laman Hall

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State of Maryland	Department of He	ealth and Me	ntal Hygiene

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cinculos Lama		1- For State Of Maryland / Department of Health and the Certificate of Death	Mental Hyg		g. No.	200	8 1623
Physicia	n/	1. Decedent's Name (First, Middle,Last)	2.	Date of Deatl Month		Year	3. Time of Death
Medical Examir		Demetris Lamarr Hall		May 5, 200)8		1716 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loc Lake Lariat Lusby	cation of Death		Calv	unty of Death ert	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24Hrs.	8. Date of Birt	h (MM/DD/	YYYY) 9. Birti	nplace (State or
Director		213-98-1631 1X M 2 F 26 Yrs. Months Days Usual Residence of Decedent	Hours Min.	09/29	/1981	Foreign Cou	ntryMaryland
any	1	10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
Maryland 28a-f show 1 at once.	٥	Maryland Calvert Lusby					1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code		10	g. Citizen	of What Coun	try?
vith the		11464 Stirrup Lane 20657 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispar	nic Origin? (Sper			d State	ean Indian, Black,
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Titem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No If Yes, specify Cuban, M				White, etc.	
after (by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No s				ecify: Bla	
hours 'natur		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation during most of working life. Do			16b. Kind	of Business/Ir	ndustry
36 hin 72 e. than	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Carpenter			Cons	struct	ion
215-0036 be filed within 72 hours after that Hygiene. tked other than "natural", the Medical Examiner.	히		.Mother's Name (F	First, Middle, N			
121 d be fi lental l arked	8		Martha H				
MD 21 nd 2 should 1 alth and Mer m 27 is mar sumatic eve	۵	19a. Informant's Name/Relationship (Type, Print) Martha E. Tate/Mother 11464 Stirrup I					Zip Code)
e, N l and 2 Health item 2 traus	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemet		Date		ation - City or	Town, State
nor Pages ent of nt: If		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Charles Memorial Co	em 05/1	0/2008	Leon	ardtow	n. MD
Baltimore, MD 21215-00 pernit. Pages I and 2 should be filed witl Department of Health and Mental Hygien Important: If tiem 27 is marked other injury or other traumatic event, the Me	ı	21. Signature of Funeral Service Licensee 22. Name and Address of					ome, P.A.
		Kyle S. Simons M01206 22955 Ho11y 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc	wood Roa	ad, Lec	nard	town, 1	
Physician /Medical		failure. List only one cause on each line.	cii as cardiac oi i	espiratory arre	331, 3110GK,	or rieart	Between Onset and Death
xaminer	- 1	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):					
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ited 1 ansit	Exa	Consequence or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical	UNPENDED X AMENDED, 27,28a-f, perME, g879 5/23/08 T	———— Т				
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ires that the signed by	b P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.			contribute to	the cause of death?
ds, Forduires	ted			24a. Was			topsy findings available
COL law re has be	Completed			autop perfoi	sy med?	prior to death?	ompletion of cause of
tal Rection: The		25. Was case referred to medical 26.Place of	Death (Check on	1 Yes	2 No	1 🗸 Ye	s 2 No
Vita ysicial his cer direct	To Be	everminor?	ile and promotion		Residence	6 🗸 Other	: Scene
1 of Vital Recing Physician: The I		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury a	_	8d. Describe I			
ision Attend or death. rector: by the f	<u>ا</u> څ	2 X Accident Investigation Fnd 5/5/2008 FNd 5:05 pm		subject			
Division of Vital Records, lat or Attending Physician: The law requirers after death. Al Director: After this certificate has been sited in by the funeral director, page 2 should be a by the funeral director, page 2 should be a by the funeral director.	ertification:	3 Suicide 6 Could not be determined (Specify) Water		or Town, S Lake Lar	tate)		ral Route Number, City
Hospid 24 hour Funer tely fil	ㅇ t	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date	and place, and d	ue to the caus	e(s) and m	anner as state	ed.
Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, do and manuer stated.		he time, date			
	Σ	29b. Signature and title of certifier 29c. License n					nth, Day, Year)
	-	O.C.M. 30. Name and address of person who completed cause of death (Item 23a)	L.		May 6	, 2000	
	- 1	David Fowler M.D. Chief Medical Examiner 111 Penn Street, Baltimore.	, MD 21201				
Sta Registr	ite	31. Date filed (Month, Day, Year) MAY 0 9 2008 Registrar's Signature					
Registi	લા	IIIAI O O 2000					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** PM 1716 2008 Nadira Ishaq 05 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center
5. Social Security Number 6. Sex 7. Age (In vrs. last birthdau Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🔀 F 43 7/17/1964 214-81-0488 Pakistan Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2X No Boyds Montgomery Md. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with intent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or introcervent, the Medical Examiner must be not you other traumatic event, the Medical Examiner must be not per traumatic event. 18331 Tapwood Rd. Pakistan 20841 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 XNever Married 2 Married Specify: Asian 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ishaq Razia Ishaq Mohammad 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18331 Tapwood Rd. Boyds, Md. 20841 Department of Health a Important: If Item 27 Is any injury or other trainonce. Mohammad Nasir / brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington 5/2/08 Adelphi, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Universal Mortuary With 411 Kennedy St., N.W. Washington, DC 20011 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septic Shock **Physician** /Medical Due to (or as a consequence of): Examiner Fungemia, Bacteremia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Congestive Heart Failure Due to (or as a consequence of): Box 68760 Physician/Medical attending pl for use as t nse IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Cardiomyopathy 2No 3 Probably 4 Unknown 1 🗌 Yes Nonischemic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient To the Hospital Community within 24 hours after death.

To the Funeral Director: After this of the Funeral Director, After this of the funeral directors and the funeral directors. this 28b. Time of 28c. Injury at Work? 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation (Month, Day Year) Injury Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P21190

31. Date filed (Month, Day, Year) State MAY 0 5 2008 Registrar

Anne Parker Frosch, 22 South Greene Street Baltimore MD 32. Registrar's Signatu

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 05-01-2008

			For State Registrar	State of Ma	arylan	•	artment of F			lental Hy	giene	2008	16246
2 % 2 % 10%	Physici	an	1. Decedent's Name (First, Middle,	,						2. Date of Do Month	eath Day	Year	3. Time of Death
	/Medic		Elsie 4a. Facility Name (If not institution,	Elizabet	h	Jewet	4b. City, Town, c	r Location	of Death	May	2,	2008 County of Death	8:55 A. ^M
	Examin	ier	Shady Grove Nurs		ah (Center	Rockvi		or Death			Montgom	
1	Funeral			6. Sex 7. Ag		last birthday)	If Under 1 Year	If Under		8. Date of Bi	rth	9. Birth	place (State or Foreign
	Director		097-03-7721	1□M 2\ F	90	Yrs.	Months Days	Hours	Min.	(Month, Di Dec 12	, 1917	New	ntry) York
	pu »		Usual Residence of Decedent 10a. State 10b. County		100 Cit	y, Town or Lo	oation						10d. Inside City Limits
	shov shov	5	,										1 ☐ Yes 2 No
	the N 28a-f	Directo	Maryland Montgo: 10e. Street and Number	mery	Ga:	ithers	10f. Zip Code				10a Citiza	en of What Cou	
	a or		816 Diamond Driv	۵			20878	t			_	ed Stat	
	ms 2;	Funeral	11. Marital Status	12. Was Decedent 8	Ever in U.	.S. 13.	Was Decedent of H		igin? (Spe	ecify Yes or No		4. Race - Ameri	can Indian,
9	or ite		1 Never Married 2 Marrie	Armed Forces? d 1 ☐ Yes 2 ☐ 1	No	i	if Yes, specify Cub 1 □ Yes 2⊠tNo			Rican, etc.)		Black, White,	
215-0036	J within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show. the Medical Examiner must be notified at	d by	3₺Widowed 4□Divorced	If Yes, Give Year or Dates:			TLL Tes ZLANO	specity.				Specify: Wh	ite
ָה ה	"natu	Completed	15. Decedent's (Specify only highest			16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	ation during mos	at of work	ing	16b. Kind	d of Business/lr	ndustry
7.7	within iene. than "the Med	dmo	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Homer		a)			Orm	Home	
ק ס	∄ ‡ ₹		17. Father's Name (First, Middle, La	Last)		Поше	liaker	18. Mothe	er's Name	(First, Middle			
yland	و ۾ ڇ ۾	To Be	Edward Werthner					A	nna	Sma1z			
<u> </u>	shound No		19a. Informant's Name/Relationship	p (Type. Print)		19b. Mailir	ng Address (Street	and Numb	er or Rur	al Route Numb	ber, City or	Town, State, Zi	p Code)
, Mar	ss 1 and 2 of Health a item 27 is other trai		Guy Jewett (Son)			816 1	Diamond D	rive,	Gai	thersb	urg, l	MD 2087	8
o ce	of He of Herr		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	3 Demoval from State	20b. F	Place of Dispo cemetery, crei	sition (Name of matory or other pla	ce)	Г	Date	20c. Loc	ation - City or T	own, State
aitimore,	permit. Pages Department of I Important: If its any Injury or o		4 □ Donation 5 □ Other (Spe		Met	tropol:	itan Crem	atory	5/2	/08	Alex	andria,	Virginia
a D	ermit lepari npori ny In nce.		21. Signature of Funeral Service Li	cense //		1 (2. Name and Addre	ess of Facili	ty De	Vol Fu	neral	Home	
_	0. □ = a 0		Joseph J	y John		Ğ) East De aithersbu	rg, N	D 20	877			
			23a, Part1. Enter the disease, of constant shock, or heart failure. List of	omplications that caused ally one cause on each lir	I the deatl ne.	h. Do not ent	er the mode of dyi	ng, such as	cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
S	Physician /Medical		Imme : Cause (Final disease or condition resulting in death)	a. Pneumon:									1 Day
•	Examiner		,	Due to (or as		uence of):							
	- W - A	er	Sequentially list conditions, if any, leading to immediate	b. Dementia		uence of):				_			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause E to U defining Cause (Disease or injury that initiated events										
'n.	be executed ician and burial-transit	Еха	resulting in death) Last	Due to (or as	a conseq	uence of):							
8/PU	tte be lysicia ne bui	edical		d									
9	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Med	IF FEMALE:				772.5						
Z D D	ath ce ttendi	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	y			23	3d. Date of deliv Month	rery Day Year
-	the a	sici	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of d	eath 5	Other (specify) _					MOTH	Day 1eai
Į.	w requires that the debeen signed by the should be detached		Part II. Other significant condition	s contributing to death bu	ut not resu	ulting in the u	nderlying cause giv	en in Part I		23e Did	tobacco us	e contribute to t	the cause of death?
ďS,	signe d be	d by	Stroke			g	idenying sauce gir	on mir are					bably 4 🛣 Unknown
ecoras	2 9 75	Completed	Channin	Vile Die									
E E	The law te has b	dm	Curonic	: Kidney Dis	ease					24a. Was auto perf		prior to co	opsy findings available empletion of cause of
	in: Ti ificate or, pa	ပ္ပ	25. Was case referred to medical					00 51		1□ Yes	2⊠No	1 ☐ Yes	2 □ No
>	Physician: The lav this certificate has ral director, page 2	00	examiner?	Hospital: 1 ☐ Inpatie	ent 2 🗆	ER/Outpatier	t 3D DOA Oth	or.		Check onl		□Other (Speci	
_	D 9 9	n: To	27. Manner of Death	28a. Date of Inju	ry	28b. Time of				28d. Describe			(9)
SION	Attending F r death. ector; After by the funera	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat	tion	y rear)	Injury		Yes 2□	No				
<u> </u>	er der recto	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At ho	ome, farm, str	eet, factory, office				(Street and own, State)	Number or Rur	al Route Number,
5	ital o rs aft ral Di led in	Çe											
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best of xaminer: On the basis of and manner sta	f examina	wledge, deat tion and/or in	n occurred at the ti- vestigation, in my o	me, date ai opinion, dea	nd place, ath occur	and due to the red at the time	cause(s) a , date and p	ind manner as solace, and due	stated. to the cause(s)
	Fo the vithin Fo the comple	Me	29b. Signature and title of certifier	and manner ste			29c. Licens	e number			29d. Date	signed (Month,	Day, Year)
			Dres-	_			n c	28656			Ма	2 2000	
	10		30. Name and address of person wi	ho completed cause of de	eath (Item	1 23a) (Type,		.0000			мау	2, 2008	
			Ravi Passi, M.D.	, 15225 Sha			oad, # 20)8, Ro	ockvi	11e, M	ary1a	nd 2085	0
	Sta	te	31. Date filed (Month, Day, Year) MAY 0.5 200	2. Registra	ar's Signa	ture							
	Registr	ar	MITI U 3 201	08 Alexen	S.	1234							

			For State Registrar		State o	of Maryla		artment of I		and Me	-	giene Reg. No.	m n n n	1001.0
*	Physici	_	Decedent's Name (Fin								2. Date of De Month		6 4 4 4	3. Time of Death
	/Medic Examir		4a. Facility Name (If not			mber)		4b. City, Town, o	or Location o		.04	4c.	County of Death	
	Funeral Director		Holy Cro 5. Social Security Number 227–36–099	6. Se		7. Age (In)	vrs. last birthday) Yrs.	Silver If Under 1 Year Months Days	Sprin H Under	24 Hrs. 8 Min.	B. Date of Bir (Month, Da 05 12	th ay, Yea <i>r)</i>	Cou	y place (State or Foreign intry) th Carolina
	yland how at			b. County			City, Town or Lo		-					10d. Inside City Limits
	h the Mar r 28a-f s notified	Funeral Director	MD Mc	ontgomer	У		Silver S	pring 10f. Zip Code				10g. Citi	zen of What Cou	1xx es 2 No Intry?
	s 23a c	eral D	11901 Crim	nson Lan		-dt-Ci	- 110	2090		-in0 (CI	Mr. Van au No		USA 14. Race - Ameri	ican Indian
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fune	11. Marital Status 1 Never Married 3 Widowed 4 N		12. Was Dec Armed F 1 ☐ Yes If Yes, G Year or [orces? 2⊠nNo ive		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No		gin? (Speci n, Puerto Ri	ican, etc.))-	Black, White	, etc.
15-00	nin 72 hou n "natura Medical E	Completed	15. (Specify o	Decedent's Edu	e completed)	1-4or 5+)	i (Give	dent's Usual Occu kind of work done DO NOT use retire	during most	t of working	ī		ind of Business/li	·
212	led with lygiene her tha				2 yr		Acco	ounting 1			First, Middle		Gover	nment
land	ld be fil ental H ked otl ic ever	To Be	17. Father's Name (First David Coe							•	inson	, Maidell	Surname	
Baltimore, Maryland 21215-0036	nd 2 shou alth and M 27 is mar rrtaumat	-	19a. Informant's Name/ Gregory Joy					ng Address (Stree Copley I						
more,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Dispositi 1 ☑ Burial 2 ☐ Cr 4 ☐ Donation 5 ☐	remation 3 🗆 F		State		osition (Name of matory or other pla Memorial		Dat			ocation - City or I	
Balti	permit. Departm Importar any inju		21. Signature of Funera			all		2. Name and Addr 217 9th.					uneral I	
	Physician /Medical Examiner	er	23a. Rand. Enter the dishock, or heart fail immediate Cause (Fina disease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter Underlying ause. Enter Underlying.	ilure. List only o	ne cause on $\begin{array}{c} \text{Liv} \\ \text{Due to} \\ \end{array}$	each line. 7er Ci: (or as a con	rrhosis sequence of):	ter the mode of dy	ing, such as	cardiac or	respiratory a	arrest,		Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physician and of for use as the burial-transit	edical Examiner	cause. Effect Orderlying Cause (Disease or injurithat initiated events resulting in death) Last		Due to	(or as a con	sequence of):							
P.O. Box		Physician/Me	IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 □ Yes 2 🖾 No 9 □ Unknown	nths?		birth 2 □ I nant at time	Fetal death 3	⊒Ectopic pregnand ☐ Other <i>(specify)</i> _	су				23d. Date of deli Month	very Day Year
	law requires that the as been signed by th 2 should be detache	ğ	Part II. Other significan	nt conditions co te Renal			resulting in the u	nderlying cause gi	ven in Part I					the cause of death?
or Vital Records,	The law reate has bee page 2 shou	Completed		_,							24a. Was auto perfo		death?	topsy findings available completion of cause of
Vita	Physician: r this certifica ral director, p	Be	25. Was case referred t examiner?	H	Hospital:			Ot	har:		Check only	one)		
on or	ding Phys n. After this funeral dii	ion: To		☐ Pending investigation	28a. Date	<u> </u>	2 ER/Outpatier 28b. Time of Injury	of 28c. Inju	4 LJ INU	28	e 5 ☐ Res 3d. Describe		6 ☐Other (Spec ry occurred	ify)
Division	ospital or Attending Physician: The law hours after death. uneral Director: After this certificate has siy filled in by the funeral director, page 2	Certification:	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e. Plac	e of injury - A ding, etc. (Sp	At home, farm, st ecify)	reet, factory, office		28	Bf. Location (City or To			ral Route Number,
	工 4 L 3	Medical C			iner: On the			th occurred at the sovertigation, in my						
8	To the within 2 To the comple	Me	29b. Signature and title	of certifier		/1	40		se number			29d. Da	te signed (Month	n, Day, Year)
'n			30. Name and ad	of Freen who	ompleted on	is of death	(Itam 23a) (Type	D006	3343	reman.		04-	28-2008	
1-	(5)		Irina Ruba	afi 1500	Fores	t Gler	n Road,	Silver S	pring,	Mary	land	2091	0	
	Sta Regist		31. Date filed (Month, D	2008	32.	Registrar's S	ignature							

Joshua M. Jones

08-03596 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day May 11, 2008 0655 hrs Medical Examiner Joshua Michael Jones 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Washington 19633 Marigold Road Hagerstown 9. Birthplace (State or Foreign Maryland 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 217-90-9193 1 X M 2 Country) 32 Aug. 14,1975 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 X No 28a-f show Maryland Washington County Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 19633 Marigold Drive 21742 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married White Yes Yes 2 No specify: 3 Widowed Divorced If Yes, Give Year Specify \$ 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Food Distrubution College (1-4 or 5+) Elementary/Secondary (0-12) Assistant Warehouse permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Service Baltimore, MD 21215-0036 1 Supervisor 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) or other traumatic event, Be William Kenneth Jones <u>Lois Ann Weller Jones</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tara Natalia Jones-wife 19633 Marigold Dr. Hagerstown MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State crematory or other place) Donation 5 Other Specify: 5-16-2008 Smithsburg. Smithsburg Crematory Marvland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 taron 23s. Part I. Enter the disease or of milications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. /Medical Death Atheroscleroticccardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Physician/Medical X UNPENDED ed by the attending physician detached for use as the burial -AM#252,27,perME,g879 5/30/08 TI IF FEMALE: 23d, Date of delivery 23c. If ves, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 V Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury Certification: X Natural 1 Yes 2 No 5 Pending in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registra

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Theodore M. King, Jr., MD.

MI.

30. Name and address of person who complete Cause of death [Item 23a]

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

29d. Date signed (Month, Day, Year)

May 11, 2008

and manner stated

772

32, Registrar's Signature

Assistant Medical Examiner

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 25

2008

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 18M 2008 James Joseph Kelly /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 584564N Aiconia PENINSULA REGIONAL CAMA If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) B. Date of Birth (Month, Day, Year) 6/15/1929 Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours 066-22-6157 78 NY Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla retrinent of Health and Mental Hygiene. ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, it will can in usit to infinity. Director 1 ☐ Yes 2 XNo MD Worcester Bishopville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10028 Mill Pond Dr. 21813 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 X Yes 2 If Yes, Give Year or Dates 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify ģ Specify: white 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automobile 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Joseph Kelly, Sr. Mary Sullivan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dori Kelly / daughter 10028 Mill Pond Dr., Bishopville, MD 21813 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If ite 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Cape Henlopen Crem. 5/8/2008 4 ☐ Donation 5 ☐ Other (Specify) Frankford, DE 21. Signature of Funeral Service Lie 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 01 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed physician al s the burial-t Due to (or as a consequence of): Box 68760 Physician/Medical requires that the death certificate as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. I signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown has been signed 2 should b 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? aw autopsy page certificate ! 21 No 1 ☐ Yes 1 ☐ Yes 2 No or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 ∐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

BA12+1

DHMH 17 Rev 1/2001

State Registrar

MAY 0 6 2008

Tank

31. Date filed (Month, Day,

29b. Signature and fittle of certifier

Carroll

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d, Date signed (Month., Dav. Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Pilar Afable Kabiling May 2, 2008 2:00 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital
ocial Security Number 6. Sex 7. Age (In yrs. last birthday) Montgomery
9. Birthplace (State or Foreign Takoma Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Oct. 12, 9. Birthplace (State or F Country) Philippines **Funeral** Year Days 1 □ M 2 K F Yrs. 218-92-1569 90 1917 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or dical Examiner must be 1000 Daleview Drive 20901 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2**XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐KNo Specify: Completed by 3€Widowed 4 Divorced Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florentino Afable Felicidad Janolino ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Primrose Court, Marco Island, FL 34145 Alejandro Kabiling, Jr./Son of Health of item 27 is 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of Hi
Important: If iter
any Injury or oth 15, 2008 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Arlington,Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W.. Silver Spring, MD 20901 23a. Part1. Ever the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician nevoscherotic /Medical Due to (or as a consequence of) Examiner Cuto Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine aw requires that the death certificate be executed heamone attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed' ospital or Attending Physician: Thours after death.

Jueral Director: After this certificate it filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner a eath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 1 Utlatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00060100 Altmins Mn Alfun Po

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

31. Date filed (Month, Day, Year)

MAY 0 5 2008

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BLVD

State

Registrar

Low Spa

AHMED, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State RegistraMEND#19a, perINF, 5/13/08, DFS, MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Ronald Kolenkiewicz 2001 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1**X** M 2 □ F 75 Director 161-28-0821 Pennsylvania Sept. 6, 1932 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show notified Maryland | Prince George's 1 √Yes 2 No **Funeral Director** Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? other traumatic event, the Medical Examiner must be 23a 12401 Starlight Lane 20715 United States 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married TYYes 2 No Yes, Give 1950-9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by Specify: 3 Widowed 4 Divorced White Year or Dates: 1958 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) National Aeronautical Elementary/Secondary (0-12) College (1-4or 5+) Geophysicist & Space Administration 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Louis Kolenkiewicz Irene Milgram ¹⁹ Jacquelyn Alli Kolenkiewicz, Spouse J. Ann Kolenkiewicz-Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12401 Starlight Lane, Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory May7, 2008 Brentwood, MD 22. Name and Address of Facility Simple Tribute 21. Sign war of Funcial Service Micenses 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final cardioresbi **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence f): Examiner metastacio Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed No autopsy 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 28a. Date of Injury (Month, Day Year) Mapner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Tes ours after death.

neral Director: A
filled in by the for 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier of person who completed cause of death (items CON 31. Date filed (Month, Day, MAY 0 Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

0 5 2008

State of Maryland / Department of Health and Mental Hygiene [] []

4/26/08 ble. 8 8/52P 8

		1 - State Registrar			Cei	rtificate	of L	Death			Reg. No.				
		1. Decedent's Name (First, Mid	dle, Last)							2. Date of De			.,	3. Time of	Death
Physi		Margaret Add	alina VDID	TDE						Month April	Day 26	2008	Year Q	Q - 15	р ^М
	dical	4a. Facility Name (If not instituti				4b. City, To	own or	Location		Whitt		County o		0.10	F
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Funera	al	5. Social Security Number	6. Sex 1 ☐ M 2 1 K F	7. Age (In yrs.			Days	Hours	Min.	8. Date of Bi	ay, Year)		Coun		ir Foreign
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ryla	_	10a. State 10b. Coun	ty	100. 01	ty, Town or Lo	Cation							'		2 No
a-f	읝	Maryland Wash	ington		Hager	stown								M 163	2 140
1 28	<u>e</u>	10e. Street and Number				10f. Zip C	Code				10g. Citi	izen of WI	hat Coun	ntry?	
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death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.				gin? (Spe	cify Yes or No Rican, etc.)		14. Race			
fler f	Ē	1 Never Married 2 Ma	Armed F arried 1 Tes	2 X No	1					Hican, etc.)			, White,	etc.	
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9 5 9 1		17. Father's Name (First, Middle	_ _		j Ow.	iici op	CIA		er's Name	(First, Middle					
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should be ind Menta is marked umatic ev	2	Albert Palmer								Gigeo					
d 2 should th and Mer 7 is marke treumatic		19a. Informant's Name/Relation	nship (Type, Print)		19b. Maili	ng Address (Street a	and Numbe	ar or Rura	I Route Numb	er, City o	r Iown, S	state, ∠ip	Code)	
C = 64 =	Н	Barbara Sewel	l – Daught					11ey		Lancas					
of H Tal	H	20a. Method of Disposition			Place of Disponentery, creation	osition (Name matory or oth	e of ner plac	e)	C	ate	20c. Lc	ocation - C	City or To	wn, State	
Pages nent of int: If it		1 🕅 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		State	se Hil			- 1	4/30	/08	Напи	oreto	N.TO	Marul	and
	eù.	21. Signature of Funeral Service		110		2. Name and				nnich	1,100			Haryr	MIII.
permit. Departi Import	ouc	Paff	1/ 11.		/.	15 E	t.74 T	con E		Hager				17/0	
		23a. Part 1. Enter the disease,	or complications that	caused the deat								.I o I'IC	1. 2.	Approximat	te
		shock, or heart failure. Li	st only one cause on	ench line.	III. DO NOL BIII	ter the mode	Of Gyin	y, such as	Odi Glac C	i iospiiatory e	111031,			Interval Bet Onset and	tween
Physicia	m i	Immediate Cause (Final disease or condition	/	Alrei	20	To	m	7º 40	260	en				yes	3
/Medica		resulting in death)	Due lo	(or as a consec	quence of):	7		1			1		1-		/
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uted J ansit	Examiner	Cause (Disease or injury that initiated events	1	4 neu	uor	no	0							2006	4
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		23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	al death 3[Ectopic pre						23d. Date Mon		_	Year
ed fe	Sic	1 ☐ Yes 2 ☐ No	4∐Preg 9□Unk	nant at time of o	death 5[Other (spe	cify)							,	
The law requires that the death the has been signed by the atter bage 2 should be detached for u	Physiclan	9 Unknown													
w requires that been signed be should be deta	by F	Part II. Other significant condi	tions contributing to	death but not res	sulting in the u	inderlying car	use give	en in Part I	/ ~	23e. Did	tobacco u	use contri	bute to th	e cause of	death?
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ding Phy h. After this funeral d	Ë	27. Manual of Death	28a. Date	of Injury oth, Day Year)	28b. Time o Injury	of 28	lc. Injun Worl	/ at k?		28d. Describe	how inju	y occurre	ed		
or Attending after death. Director: Atte	atlo		stigation			М		Yes 2□	No						
Atte	ifi	3 Suicide 6 Coul	margad 200. Flat	e of Injury - At h	ome, farm, st	reet, factory,	office			28f. Location	(Street an	d Numbe	r or Rura	I Route Nun	nber,
d in the state of	Certification;	Tomicae /	Duil	ding, etc. (Speci	'y)					Only or 10	, orac	7			
To the Hospitel or Attending Physician: within 24 hours after death to the Funerel Director: After this certifics completely filled in by the funeral director.		29a. Certifier Certify	ring Physician: To th	e best of my kno	owledge, deat	th occurred a	t the tin	ne, date ar	nd place,	and due to the	cause(s) and mar	ner as s	tated.	
Ho: 24 h Fur	edical		al Examiner: On the												5)
thin thin mple	Me	29b. Signature and little of certif		-	,			e number						Day, Year)	
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		30. Name and address of person	on who completed car	se of death (Ite	m 23a) (Type,	Print) in	r 01.	11.0	DI	Hag	ess	5752	MA	2194	2
5H-4	1	THATAB Z	- DIASTAC	7 199	114 C	leeu	000	neg	14	1	, , 4	2001	Vy	0111	
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Regi	strar	APR 2	9 2008	100 BH3.00	15. 4		3								

State of Maryland / Department of Health and Mental Hygiene -Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** May 5, Ethel Harriet Loeb 2008 4:00 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Buckinghams Choice Health Care Center Frederick Adamstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 KF 2-13-1910 Director 064-20-4207 98 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State show r 28a-f show notified at 1 ☐ Yes 2X No Director MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r 2602 A Thurston Road 21704 USA Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important if flem 27 is marked other than "natural", or iter any injury or other traument. 1 ☐Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) News Writer Journalist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest J. Wile Liberty Bell Berliner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jeanne Carrera Dghtr 7403 Fairwood Ln Falls Church VA 22046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Fields Cem | 5-25-2008 | Ridgewood, NY 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Keeney and Basford PA Funeral Home M01176 | 106 Fast Church St., Frederick, MD 21701

23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

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Appro Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Deardiac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine TENSION and (or as a consequence of): attending physician for use as the buria Branch Block Physician/Medical bundle IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the sahould be detached ☐Yes 2 No 9□Unknown 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 100 10 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 5, 2008 17 use Ave, D-1, FREDERICK, MA State

Registrar DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a 4 show any injury or other traumatic event, the Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	For State Registrar	,	Cert	ificate of L	Death		Reg. N	<u>.</u>	10600		
	1. Decedent's Name (First, Middle, Last)					2. Date of		ay Year	3. Time of Death		
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al er	4a. Facility Name (If not institution, give street and number)	4	4b. City, Town, or	Location of Deat	h	4	c. County of Deat				
	10012 PARKERSBURG RD SW		FROSTBURG ALLEGANY								
_	5. Social Security Number 6. Sex 7. Age (i		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date	of Birth h, Day, Yea	9. Birt	thplace (State or Foreign			
	232 - 26 - 1421 ^{1⊠M 2□ F}	Yrs.	World Buys	110010	02-1	4-1917	MAR	YLÁND			
	Usual Residence of Decedent	On City Tow		tion					10d. Inside City Limits		
_	10a. State 10b. County 10	0c. City, Tow	ni or Loca	Ition					1 □Yes 2 No		
င္တ	MD ALLEGANY	FROST	BURG				10= 0	Man of Man Co			
ב	10e. Street and Number 10f. Zip Code 10g. Citizen of V										
<u>0</u>	10012 PARKERSBURG RD SW		21532				UNITED STATES 14. Race - American Indian,				
nue	11. Marital Status 12. Was Decedent Ever Armed Forces?	er in U.S.	in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						Black, White, etc.		
Ϋ́	1 ☐ Never Married 2 🖼 Married 1 ☐ Yes 2 🛣 No If Yes, Give	1 ☐ Yes 2 No Specify:					Specify: WHITE				
Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	160	Docedo	nt's Usual Occup	etion	16h	16b. Kind of Business/Industry				
ete	15. Decedent's Education (Specify only highest grade completed)		(Give ki	nd of work done of NOT use retired	luring most of wo	rking			,		
Ĕ	Elementary/Secondary (0-12) College (1-4or 5+)								RAILROAD		
ರ ೧	17. Father's Name (First, Middle, Last)		£ 110 101		18. Mother's Na	me (First, M	iddle, Maide				
o Be	CHARLES LAYMAN				ANNA BO	RING	LAYMAI	V			
2	19a. Informant's Name/Relationship (Type. Print)	198	b. Mailing	Address (Street				or Town, State,	Zip Code)		
	LURA LAYMAN WIFE	i						RG, MD 2:			
	Botar Barran	20b. Place o	of Disposi	tion (Name of		Date		Location - City or			
	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BAYARD CEMETERY 05-14-2008 BAYARD, W										
	21. Signature of Funeral Service Licensee			Name and Addre	SU	WERS	FUNER	AL HOME,	P.A.		
_	111111111111111111111111111111111111111	0547						MD 215.			
	23a. Part 1. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on each line.	e death. Do	not enter	the mode of dyir	g, such as cardia	c or respirat	tory arrest,		Approximate Interval Between Onset and Death		
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/Me	IF FEMALE: 23c. If yes, outcome of	23d. Date of de	slivery								
ian	23b. Was decedent pregnant in the past 12 months? Solution								Day Year		
ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown										
문	Part II. Other significant conditions contributing to death but it	o use contribute t	o the cause of death?								
Be Completed by Physician/		2 □ No 3 □ F	robably 4 Unknown								
etec	24a. Was an 24b. Were								utopsy findings available		
g						24a	autopsy performed	prior to	completion of cause of		
$\bar{\mathbb{S}}$							Yes 2	No 1 ☐ Ye	s 2□No		
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2	1 Tes 2 Linko 1 Inpatient		Outpatient Time of	O DOA	4 Li Nursing			6 ☐ Other (Sp ijury occurred	ecify)		
on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day,)	Year)	Injury	28c. Injui Wor		∠ed. Des	CLIDE UOW IN	ijury occurreu			
cat	2 Accident Investigation M 1 Yes 2 No 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury At home, farm, street, factory, office 28f. Location (Street and Num								ar or Rural Route Number		
rtf	4 Homicide determined 28e. Place of injury building, etc.	ate)	ii riarai riodie ivanioei,								
ပ္ပ	One Cortifier 11 Contifuing Developing To the heat of my knowledge, death accurred at the time date and place and due to the councils) and manner as stated										
Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
Mec	one) and manner stated. 29b. Signature and title of certifier 29d. Date signed								nth, Day, Year)		
_	290. Dignature pand title price runner								5-17-110		
	JUV Th Warm 1 16071 10-12.								03		
	30. Name and address of Lisson who completed cause of death (Item 23a) (Type, Print) Tevry F. Williams, MD Memorial Medical Center Suite 301, Cumberland MO										
	31. Date filed (Month, Day, Year) 32 Registrar's	's Signature	ema	10/11/10	arcal (er	THEY.	NITE .	JUI, CUMD	eriana III)		
e		J. Cignature	A SEC								
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Registrar

	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 (1) (2) (1) (2)									16051		
ſ	Physicia	20	1. Decedent's Name (First, Middle, Last) 2. Date of Death							eath	E 6 0 0	3. Time of Death
	Physicia /Medic	al .	LEE DAVIS LODGE					postion of Dooth	APRIL		2008	11:53A M
	Examin	er	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK FREDERICK									
-	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs	. last birthday)	If Unde Months		f Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year)	Cor	hplace (State or Foreign untry)
L.	Director		214-28-4499 Usual Residence of Decedent	89	Yrs.				March 2	28, 1	919 Ma	ryland
	yland now at		10a. State 10b. County	10c. C	ity, Town or Lo	ocation						10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Maryland Freder	ick	F	rede						1 ☐ Yes 2X No
		Dire	10e. Street and Number	_		10f. Zi	Code				zen of What Co	
		Funeral	7109 Autumn Leaf	12. Was Decedent Ever in	U.S. 13.	Was Dece	21702 dent of Hisp	eanic Origin? (Sp Mexican, Puerto	ecify Yes or N		ited Sta	rican Indian,
36			1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ⊠Yes 2 ☐ No If Yes, Give Year or Dates: WWI		1 ☐ Yes		Mexican, Puerto Specify:	Hican, etc.)		Black, White	e, etc. nite
21215-0036		Completed by	15. Decedent's Education (Specify only highest grade completed) (Give kind of work do life. DO NOT use ret.					on ring most of work	king	(ind of Business/Industry		
212		To Be Com	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Ow	mer/	perat				etail St	tore
Maryland			17. Father's Name (First, Middle, Last)	1			18	8. Mother's Nam		e, Maiden	Surname)	
Z			Sydney J. Lodge 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Addres	s (Street and	Edna Va d Number or Rui		ber, City o	r Town, State, Z	Zip Code)
			Pearl Lodge / Wi		ı	•						nd 21702
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b.	Place of Disponentery, cre	osition (Na ematory or	me of other place)	М	Date ay 5,	20c. Lo	cation - City or	Town, State
ij			4 □ Donation 5 □ Other (Specification)) Da	rnestov			Cem	2008			Maryland
Bal			21. Signature of Funeral Service Licer	to	1	621 0		mtown Pi	ke Fr	ederi		es, P.A. yland 21702
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death									
	Physician /Medical Examiner bulyaician and bulyaician and sthe parial-transit		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	equence of):							
4.			Convertibility list and disease	rter	ery Disease							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	equeños ot):	e off):							
		Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):									
68760,		edical E	<u> </u>									
			IF FEMALE:							-		
Вох	res that the death certific signed by the attending p be detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?							1	23d. Date of delivery Month Day Year	
P.O.		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)									
	The law requires that the steep size has been signed by the bage 2 should be detache	by P	Part II. Other significant conditions	ontributing to death but not re	esulting in the u	underlying	cause given	in Part I.		id tobacco use contribute to the cause of death?		
ord	w requir been si should b	ted	HTN	-CMT					1 Yes 2 No 3 Probably			
Records,	The law cate has b page 2 sl	Completed	RECENT NSTEMI						autopsy prior to completion death?			utopsy findings available completion of cause of
			25. Was case referred to medical					26 Place of Dea	1□ Yes	2 No	1 □ Yes	2 No
r N	ing Physician: After this certific uneral director,	To Be	examiner? 1 ☐ Yes 2 ☐ No	26. Place of Death (Check only one) Hospital: 1 propatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							cify)	
0 0			27. Manner of Death 1 ■ Natural 5 ■ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?				28d. Describe how injury occurred				
Division or Vital	death ctor: /	icati	2 Accident investigation 3 Suicide 6 Could not be determined 6 Homicide 6 Could not be building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Ω	alor A s after al Dire	Medical Certification:										
	To the Hospital or Attending PhysIclan: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
										te signed (Mont	th, Day, Year)	
	. 1		Xullino				D000	63498		-	4/29/0	8
8	3+1		lakhrinder We		400 W.	,	nth St	reet	Frederi	lck,	Marylan	d 21701
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	los	de					

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month 5:20 PM 4pm Vorous 20 2008 Neta Line /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coffman Nursing Home Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Director 220-26-0589 88 June 15 1919 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Itema 23a or 28a-f show the Medical Exemples intuit be notified at Hagerstown 1 Yes 2 □ No Maryland Washington 1304 Pennsylvania Ave Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1304 Pennsylvania death U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Never Married 2 Married 1 XYes 2 ☐ No If Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify 3 Widowed 4 □ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Neuton Annie Royston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jim Davey / Friend 2031 Heritage Pines Dr. Cary, N.C. 27519 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of H ant: If ite 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) 4/29/2008 Rest Haven Cemetery Hagerstown, Maryland 21. Signatural Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that cause, the death. Do not enter shock, or heart failure. List only one cause on each, ne Approximate Interval Between Onset and Death Immediate Cause (Final Physician 711 disease or condition resulting in death) /Medical Due toffor as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed as the burial-transit Exam attending physician and Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 2 1No page 2 should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? Yes 2 No Division of Vital 1 Yes To the Hoapital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified by the funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 1 Yes 2 10 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of cegifier 29c. License number 29d. Date signed (Month, Dey, Year) D36651 completed cause of death (Item 23a) (Type, Print) RITE 100. HOGISTORN MD 2740 State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar Amended		5/6/0	ο .	artment of H rtificate of I			Reg	ene 3. No: 0 0	0	1625	
	Physici		Decedent's Name (First, Middle, I Clara		illo]	Ligot		2. Dat Ma	te of Death nth Y	2008	Year	3. Time of D 4:55 A	
	/Medic Examir		4a. Facility Name (If not institution, g		er)		4b. City, Town, or Silver	Spri	ng		4c. County of	omer		
	Funeral Director		5. Social Security Number 568-81-0823 Usual Residence of Decedent	.Sex 7. 1□M 2√2 F	Age (In yrs. 84	last birthday) Yrs.	If Under 1 Year Months Days	If Under a	Min. 8. Dat MoV	e of Birth	923 I	9. Birthp Cau P hil	place (State or I ntry) ippines	-oreign
	a-f show	ctor	10a. State 10b. County Maryland Montgor	mery		y, Town or Lo Silver	Spring					1	10d. Inside City X□Yes 2	
	3a or 28	I Dire	10e. Street and Number 3953 Lantern S	treet			10f. Zip Code 209	02		109	g. Citizen of W		ntry?	
980	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23a or 28a-1 show ther then Medical Ever inset reast be redified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married **Midowed 4 Divorced	12. Was Decede Armed Foro 1 1 Yes 2 If Yes, Give Year or Date	rs? □ No	- 1	Was Decedent of H If Yes, specify Cuba	ispanic Origin, Mexican	gin? (Specify Ye , Puerto Rican,	es or No- etc.)		k, White,	can Indian, etc. lipino	
21215-0036	d within 72 ho piene. ir then "natur ine Medical I	ompleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4	or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired Emaker	ation during mosi i)	t of working	16	Own He		dustry	
Maryland	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, La Pastor Castille						r's Name <i>(First,</i> .a Oliga		aiden Sumame	θ)		
	alth and N		19aEstellita Cruz/	z ^(Type, Print) Daughter			ng Address <i>(Street</i> 3 Lantern							
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23s or 28s-f show amy injury or other traumatic event, the Marical Ever intermest be notified at once.		20a Method of Disposition The Burial 2 Cremation 3 4 Donation 5 Other (Spe 21. Signature of the art Service Lice	cify)	20b. F	orrubi Cene	sition (Name of matory or other place Municip tery 2. Name and Addres 013 Annap	oal 5	Date 5/17/200 y Rendon Rd. Lan	8 Pc	Funer	io, al H	Philipp ome	ines
Sales and the sa	Pnysician /Medical Examiner	ner	23a. Pant. Enter the disease, or or specific contents of the c	aDue to (or		rar Can		ng, such as	cardiac or respi	ratory arres	st,		Approximate Interval Batwe Onset and De	een eath
x 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	/Medical Examiner	IF FEMALE:	c. Due to (or d. 23c. If yes, outco	as a consec						23d. Date	e of deliv	erv	
.O. Box	that the death red by the atter detached for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birt	h 2 ☐ Feta nt at time of c	al death 3[Ectopic pregnancy Other (specify)				Mor		Day Ye	ar
rds, P	quires that in signed b uld be deta	by	Part II. Other significant condition	s contributing to dea	th but not res	sulting in the u	nderlying cause giv	en in Part I	. 23			ribute to t	the cause of dea	
Il Records,	The ate h	Completed							_	la. Was an autopsy perform Yes 2	ed? p	rior to co leath?	opsy findings avompletion of cau	
Vital	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inc	ationt 2] ER/Outpatier	nt 3 DOA Oth	0.0	of Death (Checursing Home			ar (Snaci	· (4)	
of	ding After fune	I	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of (Month,		28b. Time o Injury	f 28c. Injur Wor	4 🗆 140	28d. De		v injury occum		197	
Division	Dir	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 288. Place of	f Injury - At h , etc. <i>(Speci</i>	ome, farm, st	reet, factory, office			cation (Stre ty or Town,		er or Rur	al Route Numb	er,
	ne Hospital n 24 hours a ne Funerel l	Medical (Physician: To the bastaminer: On the bastand manne	is of examina									
	To the within 2 To the complete	Ň	29b. Signature and title of certifier	econ			29c. Licens	e number 9142			d. Date signed May 1,			
R	(5)		30. Name and address of person w	no completed cause	of death (Iter	m 23a)(Type, ia Ave	#205 Sil	ver S	pring, 1	MD 20	902			
	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 2 2008	32. Reg	jistrar's Sign	The same								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** Mary L. Kelly Major May 2008 11 1:48A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Keymar If Under 1 Year | If Under 24 Hrs. 7033 Keysville Rd. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 New York 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 1□ M 2ĂF 98 Director 105-03-4100 16, 1910 Usual Residence of Decedent 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.

?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evanther must be notified at 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Director Florida Lee Fort Myers Beach 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 130 Bahia Via 33931 Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. \$ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony Kelly Nellie Liden ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl
Department of Health an
Important: If item 27 is r
any injury or other traur 7033 Keysville Rd. Keymar, MD 21757 Michael A. Major/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State A11 County Cremation 5/13/2008 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Lige attaine (New Windsor, MD 21776 310 Church St. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician _e 0 ailal Lea disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner a al eur: Se juentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician for use as the burial be Physician/Medical 0 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) ed by the a o. 1 ☐ Yes 2 KNo 9 Unknown σ. signed by I pe deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 18s autopsy page perform certificate 2 No 1 ☐ Yes or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)residence Hospital: 1 Yes 2 No After this c funeral din ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No after death. 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EL-

(Check only one)

)our 31. Date filed (Month, Day,

29b. Signature and title of certifier

la

32. Registrar's Signature ORIGINAL.

10

IERI

29c. License number

29d. Date signed (Month, Day, Year)

08-03296 Adrian Milstead

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

Adrian ivilistead	1- For State Certificate of Death						eg. No.	201	18 1525		
Physicia		Registrar 1. Decedent's Name (First, Midd						Date of Dea Month	th	Year	3. Time of Death
Medical Examin		Adrian	Alexon		Milstead	ity, Town, or Loca	ation of Dooth	April 30, 2	2008	County of Death	0118 hrs
1		4a. Facility Name (if not institution 8037 Gambrill Park R	-)		ederick	ation of Death			ederick	
Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs. Ia			Under 24Hrs. Hours Min.	_	rth(MM/DE	Foreig	thplace (State or gn
Director	L	502-17-8882	1 X M 2 F	22	Yrs.	Onlins Days	Tiours Iviiri.	Apr.	1,198	6 Co	^{untry)} Guam
, any	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location						10d. Inside City Limits
ind show a	۱	Maryland Frede	rick	М	yersville						1 Yes 2 No
Maryla 28a-f	ect	10e. Street and Number			10f	. Zip Code			0g. Citize	n of What Cou	ntry?
ith the 23a or notifie		11308 B Highla	and School R		S 13 Was De	2177:		necify Yes or No	D- 14	USA 4. Race - Amer	ican Indian, Black,
eath w	Funeral		Armed Forces			exican, Puerto			White, etc.		
after d	Ž		vorced If Yes, Give Yeer or Dates:			2 X No sp				pecify:	White
hours	Completed by	 Decedent's Education (Spe Elementary/Secondary (0-12) 				Sa. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					Industry
336 thin 72 ne. • than edical	nple	10	Sollogo (1 vi ol	0.7	Ride	Operator	r		Amu	sement	Park
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		17. Father's Name (First, Middle		. 1	_ 1	18.1		(First, Middle,			
2121 uld be f Mental marke	To Be	Rex 19a. Informant's Name/Relation:		ilste		dress (Street an	Cinc d Number or F	•		hornbe:	•
MD 2 shorth and 27 is umatic	- 1	Rex Milstead/F							_		MD 21773
s 1 and of Health		20a. Method of Disposition 1 Burial 2 X Crematio	n 3 Removal from S		Place of Disposition crematory or other p			Date	20c. Lo	ocation - City o	r Town, State
Baltimore, permit. Pages 1 at Department of Hee Important: If ite		4 Donation 5 Other S	Specify:	St	auffer Cr	ematory and Address of		5/2008		derick	
Ball permit Depart Impor	4	21. Signature of Funeral Service	Licensee			ond Address of Opossui					-
Physician	_	23a. Part I. Enter the disease, of failure. List only one cause	complications that cause	d the death							Approximate Interval Between Onset and
'Medical xaminer		Immediate Cause (Final disease	e a. Chest Injuries								Death
		or condition resulting in death)	Due to (or as a con	sequence o	if):						
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con	sequence o	f);						
- L	xami	(Disease or injury that initiated events resulting in death) Last	C.	sequence o	of):						
xecuted n and - transit	alE		d				_				
60, ate be ex hysician	Medical Examiner	UNPENDED IF FEMALE:	AMENDED 23c. If yes, outcome	ome of prec	nancv				23d.	. Date of delive	rv
6876 ertifical ding ph		23b, Was decedent pregnant in past 12 months?	the 1 Live birth		2 Fetal d	eath 3	Ectopic pregna	ancy		Month	Day Year
Box 687 e death certifice the attending p	ysician/	1 Yes 2 No 9 Ur		at time of de	other	(Specify)					
, P.O. Box 68760, res that the death certificate be ex signed by the attending physician be detached for use as the burial-	y Phy	Part II. Other significant cond	itions contributing to dea	ath but not r	esulting in the unde	rlying cause give	n in Part I.				o the cause of death?
S, P	ed by							1 Y			obably 4 Unknown
cords, law requirents has been a	Completed							auto	opsy formed?		completion of cause of
tal Rec	S	25. Was case referred to medic	oi I			26 Place of	Death (Check	1 Yes	2 No	1 🗸	Yes 2 No
Vital I hysician: this certifi I director,	o Be	examiner? 1 ✓ Yes 2 No	I I - a - it al.	tient 2	ER/Outpatient 3	- IO+	201	ng Home 5	Resider	nce 6 🗸 Oth	er: Scene
Division of Vital Records, P.O. also or strenging Physician: The law requires that it as after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.	-1	27. Manner of Death	28a. Date of Ir (Month, Day Apr 28, 200	njury (Year)	28b. Time of Injury			28d. Describ		ry occurred object collis	ion
Sion vitendi death. ctor:	atio		estigation		0110 hrs		2 V No				Rural Route Number, City
Division spital or Attend rours after death. neral Director:	Certification:	det	uld not be ermined (Specify) L		nome, farm, street, fa eet	actory, onice built	aing, etc.	or Town, 8037 Gamb	State) rill Park F	Road, Freder	ick, MD
<u> </u>		29a. Certifier (Check only 1 Certifying I	Physician: To the best of	my knowled	dge, death occurred	at the time, date	and place, an	d due to the ca	use(s) and	manner as st	ated.
To th withir To th compl	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the company of the compan						umber	- une unie, da			fonth, Day, Year)
O.C.M.E.						April 30, 2008					
		30. Name and address of person	•			L					
L		Zabiullah Ali, M.D.	Assistant Medical I		3-2	Street, Baltim	ore, MD 2				
St Regist	ate rar										

DHMH 17 Rev 1/2001 OCME 2006

	For APIETIC 1/7000 FEROMATE GO WHAT YIADDI /// State Registrar	Certificate of Death
Physician /Medical	1. Decedent's Name (First, Middle, Last) JOSEPH DELMAR MAHER,	JR.
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De

Reg. No. 5 2<u>008</u>

2. Date of Death APR 25

4c. County of Death

1:12 PM

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit within 24 hours after death.

To the Funeral Director: After this

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Be Completed by Physician/Medical Examiner completely filled in by the funeral director, Certification: To Medical

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

ROBERT F. BROWNING

CI 	NATIONA	L NAVAI	MEDICAL	CENTER	{		BET	HESDA	1			MO	NTG	OMERY	
	5. Social Security No. 149-2784		6. Sex 1 🖾 M 2 🗆 F	7. Age (In yrs	Ver	Months	er 1 Year B Days	If Under Hours	Min.	8. Date of B (Month, D Dec. 1	irth Day, Year 6, 20	918 1 08	Co	thplace (Sta ountry) w Jers	ate or Foreigi sey
<u>.</u>	Usual Residence of 10a. State	Decedent 10b. County		10c. C	ity, Town o	r Location		-							le City Limits
cto	Maryland		ederick	N	ew Mai										1es 244100
ä	10e. Street and Nur	mber				10f. Z	ip Code				10g. C	itizen of \	What Co	ountry?	
ra	6920 Gree	n Vall						L774						State	
nne	11. Marital Status		Armed F		U.S.	13. Was Dec If Yes, sp	edent of H ecify Cub	ispanic Ori an, Mexicai	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	lo-		e - Ame ck, Whit	erican India: e, etc.	n,
Be Completed by Funeral Director	1 Never Marri		If Ves C	2 □ No Bive Dates: WWII		1 🗆 Yes	2 🔀 No	Specify:				Specify	γ: 	Whit	te
etec	(Spec	15. Decedent	s Education of grade completed	i)	16a. De	ecedent's Us live kind of v e. DO NOT	ual Occup vork done	ation during mos	t of work	ing	16b. l	Kind of B	usiness,	/Industry	
dmo	Elementary/Seco	ndary (0-12)	College 4	(1-4or 5+)			use retired .one1	a) 			U. S	S. A:	ir F	orce	
Se C	17. Father's Name ((First, Middle,	Last)					18. Mothe	er's Name	e (First, Middl	le, Maide	n Surnan	ne)		
To E	Joseph De	lmar M	aher					Kath	ryn I	M. Gal	lagh	er			
	19a. Informant's Na	ame/Relationsl	hip (Type. Print)		19b. M	ailing Addre	ss (Street	and Numb	er or Rur	al Route Num	ber, City	or Town,	State, 2	Zip Code)	
	Magie C.	Maher/	Wife						Road	, New 1	Mark	et, l	$^{\prime}$ D 2	1774	
	20a. Method of Disp 1 XBurial 2 [4 Donation	☐ Cremation	3 □Removal from	II State		sposition (No crematory of Nat		آ كِ	ıly :	Date 7,2008			,	Town, Stat	
	21. Signature of Fu		**	MI.	LINGLO	22. Name	and Addre	ss of Facili	ty			Lingto)11,	Virgi	пта
	2301	del Z) [//[m	m/	_	Stauf	fer	Funera	al H	omes P	. A.	rick	. MD	2170	12
	23a. Part1. Enter the	ne disease, or	complications that	caused the dea	ath. Do not		_					11010	,	Approx	imate
	Immediate Cause (Final												Onset a	Between and Death
	disease or condition resulting in death)	n	a	NTRACER o (or as a conse			RHAG.	<u> </u>							
				(0, 00 0 00,00	400.000 0.).										
jer	Sequentially list cor if any, leading to im	nmediate	b. — Due to	o (or as a conse	quence of):										
Ē	cause. Enter Unde Cause (Disease or that initiated events	iniury													
Exa	resulting in death) L	ast	Due to	o (or as a conse	as a consequence of):										
cal															
edi			1								- 1				
by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent			utcome pf preg		3 □Ectopic	nregnanc	,				23d. Da		-	
sici	in the past 12 1 ☐ Yes 2 ☐	□No		gnant at time of		5 ☐ Other (Mo	onth	Day	Year
h	9 □ Unknown														
by	Part II. Other signif	icant condition	ons contributing to	death but not re	sulting in th	e underlying	cause giv	en in Part I		23e. Did	I tobacco	use con	tribute to	o the cause	of death?
							-	-		1] Yes	2 X] No	3□ P	robably 4	4 ∐Unknowr
Completed										24a. Wa	s an opsy				ngs available
mo										per 1⊟ Yes	formed?		death?	2 No	
Be	25. Was case reference examiner?	red to medical			26. Place of Death (Check only one)										
10	1 Tes 2	No	Hospital: 1	Inpatient 2[☐ ER/Outpa	ıtient 3∐ [OOA Oth	er: 4□Nu	ursing Ho	ome 5□Re	sidence	6 □Oth	ner (Spe	ecify)	
tion:	27. Manner of Deatl 1 X Natural 2 ☐ Accident	h 5 ∐Pendin investiç	g (Mo	e of Injury onth, Day Year)	28b. Tim Inju		28c. Injui Wor 1 🖂	yat k? Yes 2∐	No	28d. Describe	e how inj	ury occur	red		
ical Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determ	ined Zot. Flat	ce of injury - At Iding, etc. (Spec		, street, facto	ory, office			28f. Location City or T	(Street a own, Sta	and Numl te)	ber or R	ural Route	Number,
ical C	29a. Certifier (Check only	10 Certifyin	ng Physician: To the Examiner: On the	he best of my ki basis of exami	nowledge, d	eath occurre	ed at the ti	me, date ai	nd place, ath occur	and due to th	ne cause(e, date a	s) and m	anner a	s stated. e to the cau	use(s)

State Registrar DHMH 17 Rev 1/2001 mD

29c. License number

0101231334 (VA)

NATIONAL NAVAL MEDICAL

BETHESDA MD 20889-5600

CENTER

and manner stated.

MC

32. Registras's Signature

USN

30. Name and address of person who completed cause of death (Item 23a) (Type Frint)

APR 3 0 2008

CDR

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State RegistrareND#20a,b,c,perFH,5/12/08,DPS,Mcco Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Rita Murray Maru **?** M 5:45 2008 724 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Cita If Under 1 Year If Under 24 Hrs. lot Beltimore 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Days Hours 1 □ M 2 □XF Months 578-46-4369 Yrs. 72 Director Nov. 3, 1935 Washington, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2617 Higbee Road 20783 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Š Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien. Important: If item 27 is marked other that any injury or other traumatic means in proce. Realtor Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward John Murray Mary Margaret Rich ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Jenkins/Daughter 2617 Higbee Road, Adelphi, MD 20783 20b. Place of Disposition (Name of Met remotal) Framatory er offer place) 20c. Location - City or Town, State 20a. Method of Disposition May 9, Alexandria, VA 12 Suriar 2 Cremation 3 Removal from State Cate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 5 500 University Blvd, W, Silver Spring, amo 23a. Part 1. En yr the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Mermoniz /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ng physician and as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d, Date of delivery 3 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 X No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 24 hours a within 2 To the

Division of Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-4036

State Registrar

30. Name and address

31. Date filed

5

Ó

of person who completed cause of death (Item 23a) (Type, Print) 2401 West Belvedere Ave.

D632900

May

ician	 Decedent's Name (First, Middle, Last) 										3 Jimo of Dooth
	D 1 T 1							2. Date of De Month	D	2008 Year	3. Time of Death 03:48P M
dical niner	Bessie Louise Moderate August 1988 4a. Facility Name (If not institution, give street)	unson t and number)		4b. City, T	Town, or	Location of		April :		lc. County of Deat	
illiei a	11902 Greenhill Dr.	ŕ		Hager	rsto	wn			1	Washingto	on
al	5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs.		If Under 1 Months	1 Year Days	If Under 2 Hours	24 Hrs. 8 Min.	3. Date of Bir (Month, Da			thplace (State or Foreign buntry)
or	214-09-3658 Usual Residence of Decedent	9:	Yrs.					Sept. Sept.	9,	1916 Mar 1916	yland
	10a. State 10b. County	10c. Cit	y, Town or Lo	cation				bept.	J 9	1910	10d. Inside City Limits
tor	Maryland Washington	Hage	erstown	n							1 □Yes 2 No
Funeral Director	10e. Street and Number			10f. Zip (Code				10g. C	Citizen of What Co	ountry?
ral	11902 Greenhill Driv			217						S.A.	
nue	A A	Vas Decedent Ever in U. Armed Forces?	S. 13.	Was Decede If Yes, speci	ent of His ify Cubar	spanic Orig n, Mexican	gin? (Spec , Puerto R	ify Yes or No ican, etc.))-	14. Race - Ame Black, White	
by F	3 Widowed 4 Divorced	☐ Yes 2☐ No i Yes, Give 'ear or Dates:		1 ☐ Yes 2	No	Specify:				Specify: Whi	ite
Completed	15. Decedent's Educatio (Specify only highest grade cor	n nalated)	16a. Deced	dent's Usual	l Occupa	ation	of working		16b.	Kind of Business/	
nple		College (1-4or 5+)	life. I	kind of work DO NOT use	e retired)	unng most)	or working	,			
ပ္ပ	12		Mater	ial H							nufacturer
Be	17. Father's Name (<i>First, Middle, Last</i>) Amos Turner					Alice				en Surname)	
P	19a. Informant's Name/Relationship (Type. F	Print)	19b. Mailin	na Address	(Street a			Bakeı Boute Numb		or Town, State, 2	Zin Code)
To Be Completed by Funeral Director	, , , , ,	Niece								aryland 2	
	20a. Method of Disposition	20b. F	lace of Dispo	sition (Name	e of	i	Da			Location - City or	
	1 Surial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	vai from State	st Have		-	í i	/30/2	008	Нас	erstown	Maryland
once,	21. Signature of Funeral Service Licensee	1100	22	2. Name and	Addres	s of Facility	Rest	Have	n F	uneral C	hapel
Ы	m Th									stown Ma	ryland 21742
	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can				of dying	g, such a s (cardiac or	respiratory a	ırrest,		Approximate Interval Between Onset and Death
n	Immediate Cause (Final disease or condition resulting in death)	Athero	silero	5.1							Oriset and Death
il r		Due to (or as a conseq	uence of):								
ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underl in Cause (Disease or injury	Due to (or as a conseq	uence of):								
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.									= '3	
Exa	resulting in death) Last	Due to (or as a conseq	uence of):								
lical	d										
Physician/Med	IF FEMALE:	f yes, outcome pf pregna	nov						•		
cian	in the past 12 months?	i ⊆Live birth 2 ☐ Feta I ☐Pregnant at time of d	Ideath 3□	Ectopic pre						23d. Date of del Month	livery Day Year
ysid		9 Unknown	outil or	Journal (Spe							
	Part II. Other significant conditions contribu	iting to death but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did 1	tobacco	o use contribute to	the cause of death?
q pa	Dementin							1 🗆	Yes	2XNo 3∏Pr	robably 4 □Unknown
Completed by	Atrial Fibrill	a teon						24a. Was		24b. Were au	utopsy findings available completion of cause of
E O	,							perfo	ormed?	death?	·_
Be	25. Was case referred to medical examiner?						of Death	Check only			
P ,	1 ☐ Yes 2 ☐ No Hospi	1 Inpatient 2				4 🗆 INUI				6 ☐Other (Spe	ecify)
<u>io</u>	1 Natural 5 ☐ Pending	Ba. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28	Bc. Injury Work	rat .? /es 2∐1		3d. Describe	how in	jury occurred	
Certification:	2 Accident investigation 3 Suicide 6 Could not be	 Be. Place of injury - At ho	ome, farm, str					Sf. Location /	Street :	and Number or Bi	ural Route Number,
eri	4 ☐ Homicide determined	building, etc. (Specif	y)	,				City or To			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	29a. Certifier 1 Certifying Physicia	n: To the best of my kno	wledge, death	n occurred a	at the tim	ne, date an	d place, a	nd due to the	cause	(s) and manner as	s stated.
Medical	(Check only 2 Medical Examiner: one)	On the basis of examina and manner stated.	tion and/or in	vestigation,	ın my op	oinion, dea	th occurre	d at the time,	, date a	and place, and due	e to the cause(s)
Σ	29b. Signature and title of certifier			29c.	License					Date signed (Mont	
	1 MSRe	Lun		1	クラ	847	1		4	128/0	8
1 /	30. Name and address of person who comple										
	22911 Jefferson	RIVA 5	m 17	-/ /			mb				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** 2008 Year 25 Grant Elmer Mayberry April 6:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County 18327 Lappans Rd. Boonsboro 9. Birthplace (State or Foreign Country) District of Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 23, 1927 5. Social Security Number 6 Se 7. Age (In yrs. last birthday) 1 ÅM 2□ F Days Hours Min 80 577-32-7752 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 TNo Directo Maryland Washington County Boonsboro 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 18327 Lappans Rd. 21713 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ayes 2 1945— If Yes, Give 1948 Year or Dates: 1948 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 X No Specify: White \$ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Federal Government Lawyer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Barnhart Mayberry James Mavberry ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18327 Lappans Rd. Boonsboro, MD 21713 Dejon Mayberry-wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 4-26-2008 Smithsburg, Maryland 22. Name end Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 action as 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final heart Congestive months disease or condition resulting in death) Due to (or as a consequence of): Out to (or as a consequence of) arteru Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hypertension 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760. signed by the a has e 2 s certificate ha this certific ral director, ours after death.
neral Director: Af
filled in by the fur within 24 hours a

To the Funeral C

completely filled

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Martical Examinar must be notified once."

Physician

/Medical

Baltimore, Maryland 21215-0036

5H9+1

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

APR 30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) In Bui MD Hagerstun Opal Ct. 31. Date filed (Month, Day, Year)

2008

32. Registrar's Signature

12 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

21740

29d. Date signed (Month, Day, Year) 05/09/2008

Private Company March Land Prince George's Report Land Chevroll Prince George's Company Land Chevroll Prince George's Chevroll Prince George's Chevroll Prince George's Chevroll Prince George's Chevroll Prince George's Chevroll Prince George's Chevroll Prince George's Chevroll Prince George's Chevroll Prince George's Chevroll Prince George's Chevroll Prince George's Chevroll Prince George's Chevroll Prince George's Chevroll Prince George's Chevroll Prince George's Chevroll Prince Geor				For State Registrar	State of M	Maryland / Dep Ce	partment of Fertificate of		nd Mental Hy	/giene Reg. No.	CUU	8 162	61
As a Catherine Name As a Catherine Name As a Catherine Name As a Catherine Name As a Catherine As			X		Last)								Death
The company of the co	lę.			Mary Cather	ine Mars	shall							M
Social Security Number Service Service The Content of Service Serv							4b. City, Town, o	r Location of E			County of D	eath	
The content of the													
T15-34-3816 7 (See 1) Sept. 30, 1936 Mary 1 and 1 Sept. 30, 1936 Charry 100, 50 Size 100, 50 Siz				Social Security Number 6					Min. (Month, D	ay, Year)		Country)	Foreign
The Country of the Co	l.	Director			74	71			Sept.	30,	1936	Maryland	
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 9:298 M ERNARDA ONIZUK 03 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CECIL ELKTON HOSPITTA L UNION If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days **★** M 2 F July 18,1954 Director 221-30-9952 53 Wilmington, DE Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Directo DE New Castle Newark 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be in Funeral 111 Willow Tree Lane death 19702 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Itel 1 ★Yes 2 No If Yes, Give Year or Dates: 1972 1 Never Married 2 Married 3altimore, Maryland 21215-0036 white 1 ☐ Yes 2 ♣No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 truck driver self-employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernard A. Onizuk Evelyn Lynch ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Onizuk (brother) <u>717 Parkman Drive Bear, DE</u> 19701 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or of once. 1 ☐ Burial 2 【SCremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Silverbrook Crematory May 6,2008 Wilmington, DE M00783 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCrery Funeral Homes, Inc. 3924 Concord Pike 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE ON CHROMIC RENAL FAILURE disease or condition resulting in death) /Medical HEART FAILURE CARDIOMYOPATHY Examiner ONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed ACIDOSIS RESPIRATORY attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 HYPERKALEMIA 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed CHRONIC OBSTRUCTIVE PHYLOWARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2X No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D. 00064670 03 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WBUNAMA 106 BOW ST. MONIQUE UNION HOSIPITAL State 2008 Registrar

DHMH 17 Rev 1/2001

Registrar

MAY 0.5 2008

08-03457	
Brian Proctor	

	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2008									
Physician/ ledical Examiner										
7	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Hospital Center Cheverly 4c. County of Death Prince George's									
Funeral Director	5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 7. Age (In yrs. last birthday) 4.3									
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ith the Maryland 23a or 28a-f show notified at once. al Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14105 Kendalwood Drive 20772 USA									
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Mostra To Be Comple	John Proctor Mary McFadden									
imore, MD 2121 Pages 1 and 2 should be fi ment of Health and Mental i tant: If item 27 is marked or other traumatic event, To Be	19a. Informant's Name/Relationship (Type, Print) Mary Proctor (Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 0772 14105 Kendalwood Dr. Upper Marlboro Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State									
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Physician	Tyrone J. Young 719 Kennedy St. NW Wash 23a. Part / Enter the disease, or complications that caused the death. Indicate the mode of dying, such as cardiac or respiratory arrest, shock, or heart failured its only one cause preach line. Approximate Interval Between Onset and									
/Medical -xaminer	Immediate Cause (Final disease or condition resulting in death) a. Coronary artery acute plane runture with thrmobus formation Due to (or as a consequence of): b. Atherosclerotic cardiovascular disease									
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physic upletely filled in by the funeral director, page 2 should be detached for use as the burilical Certification: To Be Completed by Physician/Med										
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Division of Vital Records, P.C tal or Attending Physician: The law requires that its after death. al Director: After this certificate has been signed led in by the funeral director, page 2 should be detain by the funeral director, page 2 should be detained in by the funeral director.	24a. Was an autopsy prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No									
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Sion of Vital Rec Attending Physician: The I death. ector: After this certificate I by the funeral director, page cation: To Be Corr	27 Manager of Death 28g Date of Injury 28h Time of Injury 28c Injury at Work? 28d Describe how injury accurred									
Division o ospital or Attending hours after death. Innertal Director: After y filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide Homicide 1. Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
To the Hospital within 24 hours To the Funeral completely filled										
To To con	and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 6, 2008									
	30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
Stat Registra	e 31. Date filed (Month, Day Year) 32. Registrar's Signature									

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 7:10 p M Martha Elizabeth Ann Pollitt 4/28/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Takoma Park Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 ☑ F Yrs Director 70 578-50-6928 9/24/1937 Washington,DC Usual Residence of Decedent with the Maryland 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 1 ∑Yes 2 ☐ No Director Prince George's Mt. Rainier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 7 must be n 4027 36th Street 20712 United States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral ral", or Items 2 Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No White ģ Specify: 3 Widowed 4 □ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the M Elementary/Secondary (0-12) College (1-4or 5+) Mail sorter Direct mail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 7 is marked of traumatic even Ernest Bradley Olsen, Sr. 2 Mary Magdalene Fisher 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is Curtis Pollitt 4027 36th Street, Mt. Rainier, item 27 other to MD20712 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of F. Important: If ite any Injury or other 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 5/1/08 Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 onstan 140 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed Exami that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a a I Inknown 9 Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? 1 ☐ Yes certificate 2 No 2 ☑ No Attending Physician: funeral director, Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ို 1 🖾 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural death. 1 Tes 2 No 2 Accident after death the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined ō within 24 hours a Hospital 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License numbe Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAY 0 2 2008

Ave. Suite 205

Carroll

7610

32. Registrar's Signature

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		1 - State Registrar		C	ertificate of L	Death	F	eg. No	2000	10200		
Physicia	ın	1. Decedent's Name (First, Middle					2. Date of Dea Month	Da	y Year	3. Time of Death		
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the f	Director	MD PRINC	E GEORGE	DISTRICT	10f. Zip Code		1	10g. Cit	izen of What Cou	intry?		
h with	a D	615 - 60TH PLAC	CE		20743	3		II	S. A.			
items increme	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 1	3. Was Decedent of Hi If Yes, specify Cubar		pecify Yes or No-		14. Race - Amer Black, White,			
ours after rral", or it Evernin	by F.	1 Never Married 2 Marr	ied 1 ŽiYes 2 ☐ If Yes, Give	No	1 ☐Yes 2 X No	Specify:	r riodri, oto.,		Specify: BLA			
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filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, I'm Medical Evaninar must be notified at	Completed	Liententary/Secondary (0-12)	2 YEARS) +)		CHAUFFER	2	U.S	OFFICE			
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d 2 sk Ith an Ith an Itaur		19a. Informant's Name/Relations STEPHANIE D. P.			or Town, State, Zi							
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, It as Medical once.	- 1	20a. Method of Disposition		20b. Place of Dis	sposition (Name of rematory or other place		Date		ocation - City or T			
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rmit. partin porta y inju ce.	Ì	21. Signature of Funeral Service		1	22. Name and Addres	s of Facility PI	NCKNEY-S	SPAN	GLER F.	н.		
99 E # 9		Modere	-C, Tine	kney	524 - 8TH	ST., N.	E. WASH	., D	C 20002-	-5236		
		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	the death. Do not ne.	arter the mode of dying	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death		
Physician		Immediate Cause (Final disease or condition resulting in death) a. FATAL CARDIAC ARRYTHMIA										
/Medical Examiner		Due to (or as a consequence of):										
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leath atter	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			9	23d. Date of deliv Month	very Day Year		
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sician; The la certificate ha irector, page 2							perfor 1 🗆 Yes		death? 1 □ Yes	2√ No		
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r Atterderie de irecto	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	and 28e. Place of Infl	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (S City or Town	treet an n, State	d Number or Rui	ral Route Number,		
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Host 24 ho Fune	Medical	29a. Certifier (Check only one) 1 Certifyin 2 Medical	g Physician: To the best Examiner: On the basis o and manner sta	f examination and/o	eath occurred at the time investigation, in my op	e, date and place, pinion, death occur	and due to the dred at the time, of	cause(s late and) and manner as I place, and due	stated. to the cause(s)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, t	ĕ	29b. Signature and title of certifier	A liu manner sta	atou.	29c. License	number	2	29d. Da	te signed (Month,	, Day, Year)		
		D209R9						9 4/28/08		8		

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar ELWOOD HOLLAND,
31. Date filed (Month, Day, Year) MAY 0 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. 6005 LANDOVER RD. 32. Registrar's Signature...

CHEVERLY, MD 20785

Amended Item 23a Part I Lines b&c per Physician 05/07/08 Carroll Co., wj1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Phillip Russell Pedone 2008 10:45 a^M May 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 02 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1919 1**⋤**M 2□F Months Days Hours 220-01-2177 MD Director 88 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 □Yes 2 📉No be notified Carroll Westminster Director MD 10f. Zip Code 21157 10e. Street and Number 10g. Citizen of What Country? ò 505 High Acre Drive 23a **Examiner** must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Y☐Yes 2☐ If Yes, Give Year or Dates: 2□No WWII 1 ☐ Never Married 2 X Married P. 1 ☐ Yes 2 🗓 No Specify: ò 3 Widowed 4 Divorced White 'natural' Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than the M Elementary/Secondary (0-12) College (1-4or 5+) Koester's Bakery 12 Purchasing Agent 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Abel Phillip Paul Pedone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 505 High Acre Drive T-31 Westminster, MD Audrey Pedone/wife permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr. once. 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation, Inc 5/5/2008 Hampstead, MD 4 □ Donation 5 □ Other (Specify) Printed Tuneral Home and Chapel, P.A. 21. Signature of Funeral Service Licensed 21157 412 Washington Road Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Rena Physician /Medical Due to (or as a consequence of) **Examiner** Hypertension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami **Kidney Stones** burial-trar Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown page 2 should Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1□ Yes 2□No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ D0A 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician:

death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital within 24 hours a To the Funeral C

31. Date filed (Month, Day, Year) State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

MAY 0 5 2008

and manner stated.

29c. License number

D0066184

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Memorial Avenue Eid Almutairy, MD

21157 Westminster, MD

🥰 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 3, 2008 Physician William G. Parr 5:30 а м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospice Dove House | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Apr 14, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 217-20-8149 1**X** M 2□ F 82 Maryland Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland Mental Hygiene. 10h County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Westminster Carroll 1 ☐Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21157 3816 Ridge Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify: Completed by Specify: white WWII 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Social Security Elementary/Secondary (0-12) College (1-4or 5+) Admin. Clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna A. Corless William P. Parr 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Stoner Avenue, Westminster, MD 21157 Gail Jones, guardian 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5/8/2008 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 any ir Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** METASTATIC CARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an DIABETES MELLITHS page 2 autopsy performed2 certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital P 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

29b. Signature and title of certifier

VINCENT

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rioces Ja

32. Registrar's Signature

NITOI

MJL

Saltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Ins

29c. License number

D01663

WESTMINSTER

29d. Date signed (Month, Day, Year)

		State of Maryla				-	_	DIC.	
		1 State		rtificate of l			eg. No. 🤌 🌘	0.0	10000
		Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Dea	th	I U O T	3. Time of Death
Physici		Thomas K Reile	11 -			Month	Day	Year 2008	1159 AM
/Medi Examir		4a. Facility Name (If not institution, give street and number),	0	4b. City, Town, or	Location of Death		4c. County	of Death	, , , ,
Sale of		University of Maryland		Baltimo			В	altimo	
Funeral		1√1M 2□E	vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	9. Birthpla Countr	ace (State or Foreign
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DUSO nours aft ural", or	by F	1 ☐ Never Married 2√ Married 1 ☐ Yes 2 √ No If Yes, Give 1 ☐ Yes 2 0 ☐ No Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify	v: Wh	ite
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be fill de other of other othe	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam			,	
Id I JIGITU Z IZID-DUJO 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	은	Emory C. Reiley, Jr. 19a. Informant's Name/Relationship (Type. Print)	19b Maili	ng Address (Street		tte M. S			Code
and 2 s ealth an n 27 is I eer trau		Debra A. Reiley / wife		Ruby Ln.,					oude)
if e, INIAI yilatifu ZIZIO-UUOO s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	1 8	20a. Method of Disposition 20		osition (Name of matory or other place		Date	20c. Location -		n, State
Pages nent of I		I Dunai 2 Li Cremation 3 Hemoval Irom State		e Cremato	1	10/08	York,	PA	
partification of permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other traugnose.		21. Signature of Funeral Service Licensee	2	2. Name and Addres	ss of Facility	& Cnom	ation C	onton	Inc
6 8 2 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	2 3	Meheld Dayotte		2. Name and Addres Diehl Fun 87 S. Mai	n St., Bo	0×1031	Mt. Wo	lf, P	17347
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lospit hour unera		29a. Certifier (Check only 2 Medical Examiner: On the basis of exam	knowledge, dea	th occurred at the tir	me, date and place,	, and due to the o	cause(s) and m	anner as sta	ated. the cause(s)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	one) and manner stated. 29b. Signature and title of certifier	· · · · · · · · · · · · · · · · · · ·	29c. Licens	e number		29d. Date signe	nd (Month F	Pay Voari
F W F 8		San Warl		1	1.77	27-	STILL	よ / っ	106
•		30. Name and address of person who completed cause of death (Item 23a) (Type.	Print)	0 00	0'	3 [UIL	
		Sual MLD	L2 S.	G-184	in E	SI	Batti	more,	MD 21201
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Si	ignature	of a					
Regist		MAY 1 9 2008	1	200					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** May Day 2008 Year Atlee Radcliffe, Jr. 8 Albert 10:10 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Center Frederick Frederick 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/26/1916 Birthplace (State or Foreign Country) 1 X M 2 □ F Days Hours Min 216-14-5107 91 Maryland Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Director 1√2 Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 146 Fairview Avenue 21701 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 No Specify: 2 Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Bank Examiner Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dr. A. Atlee Radcliffe, Sr. Alberta Mullinix 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 146 Fairview Ave., Frederick, MD 21701 Elizabeth Radcliffe / wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Smithsburg Crematory 5/10/2008 Smithsburg, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Keeney & Basford Funeral Home garquelle 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Heart Disease disease or condition resulting in death) vears Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 2 Accident 1 □Yes 2 □No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

law requires that the death certificate be executed Box 68760 P.0. Division of Vital Records, Hospital or Attending Physician: The

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State Registrar

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29a. Certifier

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29b. Signature and title of certifier

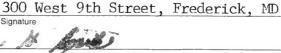
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cause of death (Item 23a) (Type, Print)



1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 16428

29d. Date signed (Month, Day, Year)

05/09/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** E11en C. Reilly May 1, 2008 6:50 p. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 120 Burgess Hill Way Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** 1 M 2 ₩ F 064-34-6347 66 Dec. 23, 1941 New York Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h. County 1 TorYes 2 □ No Director Maryland | Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 120 Burgess Hill Way 21702 USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ▼ If Yes, Give Year or Dates: 2**X** No 1 Never Married 2 Married 1 ☐ Yes 🏝 No white Specify Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant General Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Reilly Eleanor Maguire 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kerry Frost - Daughter 10860 Bethesda Church Road, Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of He Important: If iten any injury or oth 20a. Method of Disposition **X** Burial 2 ☐ Cremation 3 ☐ Removal from State 5-8-2008 Gates of Heaven Hawthorne, New York 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final liver Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): wto. minu Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Vear Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 🗌 Yes 2 No 3 Probably 4 Unknown pleted Was al. autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes

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То Ве Соп	25. Was case referre examiner? 1 ☐ Yes 2 🔥 N		Hos	spital: 1	2	ER/Outpatient	3 🗆 1	DOA	-
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rei	cian.	To the heet of m	v kno	wledge death	CCUITE	ad at t	the time d	ate and place	and	due to the cause(s) and manner as stated	

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledgram and manner stated.		
29b. Signature and title of certifier	29c. License number DOOS 8108	29d. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) 31. Date filed (Month, Day, Year) 32. Registras's Signature	(Type, Print) and Ave. Baltimore, M	0 21205 Dr. Zhiping Li

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 3.00AM May 2008 aymone /Medical 4c. County of Death 4a. Facility Name (If hot institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Bay View Care Center
7. Age (In yrs. last birthday) HOOKINS 1-timore Johns If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Min. 1 € M 2 🗆 F Yrs. 5/5/1936 PA Director 159-30-4665 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location ahow 10a. State 10b. County i Hygiene. other than "natural", or flems 23a or 28e-f ahow vant, Ina Medical Examinar must be notified at 1 ☐ Yes 2 ₩No **Funeral Director** Carroll Manchester MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21102 USA 4332 Millers Station Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1955–59 1 Never Married 2 Married imore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. Completed by white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Eastalco Elementary/Secondary (0-12) College (1-4or 5+) Aluminum 11 Maintenance Foreman traumatic avant, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) .. Pages 1 and 2 should be fill thent of Health and Mental H tent: if itam 27 la marked ott jury or other traumatic avan Doris Van Tassel Robert B. Ruggles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Ruggles, wife 4332 Millers Station Road, Manchester, MD 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Department o May 5, 2008 Hampstead, MD. Hampstead Cemetery ¹ 4 □ Donation 5 □ Other (Specify) MU0741 22. Name and Address of Facility 21. Signature of Funeral Service Licensee any it Eline Funeral HOme 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) minu tes Physician intarction myocardial /Medical Due to (or as a consequence Examiner Lue to (or as a consequence of): Sequential list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Cher (specify) the 9 🗆 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 100 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 Yes 2 100 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Destritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Lia

agistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

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y Alexander	Funeral				. Age (In yrs.	last birthday)	If Under 1 Ye	ear If Under:	8. Date of Birth		Carroll 9. Birthplace (State or Foreign			
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36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, the Me Teal Examiner must be notified at	by Fu	1 Never Married 2 Marrie	ed 1 Tes 2	2 XNo		□Yes 2⊠		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, todan, otony		Specify		
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0	nding .th. r: Afte e fune	tion	1 ☐ Maturai 5 ☐ Pending 2 ☐ Accident investig		, Day Year)	Injury		Work? 1 ⊟ Yes 2 🔲 I			, , , , , , , , , , , , , , , , , , , ,			
Division or	Atter	Certification:	3 Suicide 6 Could n 4 Homicide determi	and Zoe. Place	of injury - At h	ome, farm, stre fv)	eet, factory, off	ice	2	28f. Location (S City or Tox	Street and Nun	nber or Rura	al Route Number,	
	ital o. Iris afti rai Di			1.										
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director; p	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical 8	Physician: To the bear and manners	sis of examina	owledge, death ation and/or inv	occurred at the estigation, in	ne time, date an my opinion, dea	nd place, a ath occurr	and due to the ed at the time,	cause(s) and r date and place	nanner as s e, and due t	tated. o the cause(s)	
	o the	Mec	29b. Signature and title of certifier	ани талле			29c. Lic	ense number			29d. Date sigr	ed (Month,	Day, Year)	
	⊢ > ⊢ Ó 1		Moele	MO				D 5201	35		May	5	2008	
/	WH		30. Name and address of person v		of death (Iter	n 23a) (Type, F	Print) /		7	. (1	. 1	K.A	2008 20157	
	5		BINU CHACK	3	1 5	toner	HVE	enui	C	vestm	niter	101	1 415+	
	Sta Registr		31. Date filed (Month, Day, Year)	2008 32 Re	gistrar's Signa	ature Soo	de							

			For State	State of	of Maryla		artment of H		d Mental Hy	(008	16274	
			Registrar 1. Decedent's Name (First, Middle,	Last)			inoaic or	Douth	2. Date of De			3. Time of Death	
П	Physici		Annie L			Reed	-Lucket	· + -	April	30	Year 2008	17:30p M	
	/Medio Examin		4a. Facility Name (If not institution,	give street and nu	ımber)	11000	4b. City, Town, o				County of Death	117:30p	
		•	Fort Washingt	on Hosp	ital		Fort	Washir	naton	Pr	ince G	eorges	
	Funeral		5. Social Security Number 6	S. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24 H	Irs 0 Date of Bin	t lo	9 Birth	place (State or Foreign intry)	
	Director		212-64-5100	1 □ M 2 🔀 F	56	Yrs.	Months Days	Hours	in. 2/2/19	52	Wash	ington DC	
	pu 🛾		Usual Residence of Decedent 10a. State 10b. County		100	City, Town or Lo	antina					10d. Inside City Limits	
	eho.	Ž.		_		,,						1. Yes 2 □ No	
	the N	ect	Maryland Princ	e Georg	ges	Fort	Washing 10f. Zip Code	gton		10a Citiza	en of What Cou		
	with	Ö		37 Wilson Bridge Drive 20744								mu y :	
	illed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Itema 23e or 28e-f ehow int, the Medical Examinat must be notified at	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in	n U.S. 13 \			(Specify Yes or No		SA 4. Race - Ameri	ican Indian	
10	r Iten	Fun	1 ☐ Never Married 2 ☐ Marrie	Armed Fo	orces?			an, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)		Black, White		
ဗ္ဗ	el', o	þ	3 ☐ Widowed 4 M Divorced	If Yes, Gi Year or D	ive		I□Yes 2XINo	Specify:		5	Specify: Bla	ack	
2-0036	72 ho natur	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	lent's Usual Occup	nation	working	16b. Kind	d of Business/Ir	ndustry	
2	thin	d d	Elementary/Secondary (0-12)	College (kind of work done OO NOT use retired	•	WORKING				
2	filed wi Hygien ther th	Co	12			H	omemake				estic		
<u>n</u>	ad ta b >	Be	17. Father's Name (First, Middle, La	ist)				18. Mother's N	Name (First, Middle,	Maiden S	iumame)		
$\frac{2}{5}$	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. I marked other then "naturel", or Itema 23a or 28a-f show umatic event, the Medical Examiner must be notified at	٩	Julis			Reed		Mary				homas	
Maryland	2 4 2 2		19a. Informant's Name/Relationship						Rural Route Number				
	s 1 and 3 (Health Item 27 other tr		Viola Robinson 20a. Method of Disposition	1/ Sist		338 I	nterlak sition (Name of natory or other plac	te Pass	S McDono	ugh,	Georg	ia 30252 own, State	
õ	Pages nent of int: If Its iry or o	1	1 X Burial 2 ☐ Cremation 3		State	cemetery, cren	natory or other plac	09)					
altimore,		}	4 □ Donation 5 □ Other (Special Service Li				Memoria		7/08 k Adams Fu			aryland	
B	permit. Departn Imports eny Inju			60								e PA and 20608	
			23a. Part1. Enter me disease, or co	emplications that	caused the d		or the mode of dying	ng, such as card	fiac or respiratory a	rrest,	Maryro	Approximate	
	Physician		shock, or heart failure. List or Immediate Cause (Final	ny one cause on e	each line.	Res	Airton	. Fa	duca			Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to	(or as a cons	sequence of):	- 11 40/1	7 10	-(·(J) E			24 hours	
	Examiner		Conventially list annulities a	, As	Pira	tion	PHELL	acone a	c'A		-	se hour	
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a cons	sequence of):	<u></u>					,	
	ecute and -trans	Examin	Cause (Diseese or injury that initiated events resulting in death) Last	c. 100 M	20112	4410	Dio	U.				nehour	
60,	cate be executed physicien and the burial-transit			5=	(or as a cons	equence of):	- 11	in o	104,506	c De	doset	zietrous	
98760	cate phys	dical		d		- 240	UK W	LIN	610 40 CC	C)4	1002	24-10-03	
×	death certifi e attending od for use as	Physician/Me	IF FEMALE:	23c. If yes, out	tcome of pre	gnancy				22	3d. Date of deliv	1001	
Rox	atter d for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	birth 2 ☐ F nant at time o	etal death 3	Ectopic pregnancy Other (specify)	′		20	Month Month	Day Year	
o.	t the c by the achec	hysi	1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown	9□ Unkn	own								
ري ح	requires that the de seen signed by the a hould be detached t	by P	Part II. Other significant condition	s contributing to d	eath but not	resulting in the ur	derlying cause giv	en in Part I.	23e. Did to	obacco us	e contribute to	the cause of death?	
ğ	w require been sig should b	ed	Cirroy	509	1	e L	مص		10	∕es 2□	No 3∏Pro	bably 4 Dinknown	
ပ္တ		piet							24a. Was	an	24b. Were aut	opsy findings available ompletion of cause of	
Vital Records,	sicien: The law	Completed							- autop perfo 1 Yes	rmed?	death?		
<u> </u>	Physicien: rthis certific ral director,	Be (25. Was case referred to medical examiner?					26. Place of D	Death (Check only of				
5		ို	1 ☐ Yes 2 No	Hospital:		ER/Outpatien		4 🗆 Nursing	g Home 5 ☐ Resid	dence 6	□Other (Speci	ify)	
	and and and	on	27. Manner of Death 1 Natural 5 ☐ Pending		of Injury th, Day Year	28b. Time of Injury	28c. Injur Wor		28d. Describe I	now injury	occurred		
S	ttend death stor: /	icat	2 Accident investigat 3 Suicide 6 Could no	the -		1 h		Yes 2 □ No	006 1				
DIVISION	after Direct In by	Certification:	4 ☐ Homicide determine	buildi	ing, etc. (Spe	t home, farm, stre ecify)	eet, ractory, office		City or Tox	vn, State)	Number or Hur	al Route Number,	
_	Hospitel or Attending 24 hours after death. Funeral Director: After stelly filled in by the funeral		29a. Certifier Certifying	Physician: To the	best of my l	knowledge, death	occurred at the tin	ne. date and pla	ace, and due to the	cause(s) a	nd manner as	stated	
	To the Hospitel or within 24 hours after To the Funeral Discompletely filled in	Medical	(Check only 2 Medical Ex	aminer: On the b	asis of examiner stated.	ination and/or inv	estigation, in my o	pinion, death of	ccurred at the time,	date and p	place, and due t	to the cause(s)	
	To the within 2 To the complet	Ž	29b. Signature and title of pertifier	VO			29c. Licens	e number		29d. Date	signed (Month,	Day, Year)	
Ī			> Samuel J	NYE	the	_ M	DO	05 6	292	5	Oll	8	
(5 75		30. Name and address of person M	o completed caus	se of death (I	tem 23a) (Type,	Print)	1 11	()		. 1	nelil	
	DD 4		JAMUU D (um) 31. Date filed (Month, Day, Year)	MUMI)	istrar's Sig	CIVINGS	ton KOAC	11-+, 1	NASHING	COST	MI) 20	777	
	Sta Registra			54	Uslus Signal	4	back						

			State of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hygie	0000 10075			
2.	Physicia	an	Registrar Decedent's Name (First, Middle, Last) Dulce Maria Reig		2. Date of Death	008 Year 3. Time of Death 12:20 M			
-	/Medic Examin		4a. Facility Name (If not institution, give street and number) Collingswood Nursing & Rehab.	4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery			
·信	Funeral Director		5. Social Security Number 214-52-3301 6. Sex 1 □ M 2 □ F 7. Age (In yrs. last birthday 99 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Sept. 9,	9. Birthplace (State or Foreign Country) Cuba			
and high	Maryland f show ed at	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I Maryland Montgomery Silve	Location r Spring		10d. Inside City Limits 1			
	a or 28a-st be notif	I Director	10e. Street and Number 25 East Wayne Avenue, #401	10f. Zip Code 20901	10g.	10g. Citizen of What Country? USA			
36	72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show dical Examiner must be notified at	by Funeral		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Pueric T⊟Yes 2□ No Specify:	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
Maryland 21215-0036	within 72 ene. than "na ne Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation ve kind of work done during most of work . DO NOT use retired) omemaker	16t	Own Home			
land 2	lid be filed lental Hygid ked other ilc event, th	To Be Co	17. Father's Name (First, Middle, Last) Rodrigo Ynastrilla	18. Mother's Nam	e (First, Middle, Mai	iden Surname)			
	1 and 2 should be the thealth and Mental I tem 27 is marked of the traumatic eventheat eventheat		19a. Informant's Name/Relationship (Type. Print) 19b. Ma	,	ourt, Derwood, MD 20855				
Baltimore,			d Course Comparison 2 Demonstrate Comparison	position (Name of rematory or other place) Heaven Cemetery	May 5	c. Location - City or Town, State			
Balti	permit. Page Department of Important: If any injury or once.		Lang & Daly	Funeral	Home Inc. ver Spring, MD 20901				
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due t (or as a consequence of):	enter the mode of dying, such as cardiac	4	Approximate Interval Between Onset and Death			
8760,	Examiner	dical Examiner	Sequentially liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	e To thri	je				
.O. Box 687	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medic		3 ⊟Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year			
0	w requires that in been signed by should be detail	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobad 1 ∐ Yes	cco use contribute to the cause of death? 2岁 No 3□ Probably 4□Unknown			
or Vital Records,		Completed			24a. Was an autopsy performe 1∐ Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 ☑ No			
. Vit	Physician: Th r this certificate ral director, pac	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	Other	ith <i>(Check only one)</i> Iome 5 ☐ Residenc	ce 6 Other (Specify)			
ion oi	fing Afte fune		27. Manner of Death 1 ★ Natural 5 Pending 2 Accident Accident Accident State of Injury 28a. Date of Injury (Month, Day Year) Injury I		28d. Describe how	injury occurred			
Division	i E ffe	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)			
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my knowledge, de control on the basis of examination and/or and manner stated.	r investigation, in my opinion, death occu	urred at the time, date	e and place, and due to the cause(s)			
	3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Σ	29b. Signature and title of certifier MD	29c. License number Doo6243		1. Date signed (Month, Day, Year) 5/2/2@C8			
			30. Name and address of person who completed cause of death (Item 23a) (Type SAYED EISAYYAD 97/S	Mechle (El.	2 Roci	Cyille, MOZOSSO			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 5 2008 32. Registrar's Signature	cale)					

DHMH 17 Rev 1/2001

arbara Roberts	3	1- For State	ate of Maryl		artment of rtificate of			Menta	al Hygie		- No. 0	0.0	0 16978	
Physicia ledical Exami		Registrar 1. Decedent's Name (First, Middl Barbara	le,Last)		Robei	rte			N	ate of Death	Day Yes	ar	3. Time of Death 1250 hrs	
al xou		4a. Facility Name (if not institution		umber)		b. City, To		ocation of I		ay 5, 200	4c. County			
Funeral		8024 Park Overlook D 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under		If Under 2	24Hrs. 8.	Date of Birtl	Montgo		rthplace (State or Foreign	
Director		578-96-3405	1M 2XF	40	Yrs.	Months	Days	Hours	Min. S	EP 22,	1967		ountry) aryland	
any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Location	on							10d. Inside City Limits	
	ř	Maryland Montg	omery		hesda								1 Yes 2 X No	
th the Maryland 23a or 28a-f sho notified at once.	irector	10e. Street and Number				10f. Zip C				10	g. Citizen of W	hat Cou	ntry?	
vith the s 23a o	al Dir	8024 Park Over		cedent Ever in U	IS 13 Was	20817 13. Was Decedent of Hispanic Origin? (Specify Yes or					United States No- 14. Race - American Indian, Black,			
death v or item	Funeral		Never Married 2 Married Armed Forces?			s, specify						te, etc.	real maian, block,	
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	þ	3 Widowed 4 Div	or Dates:	er	1 16a. Decedent	Yes 2 X			ad of work	done	Specify:			
6 3 🗇	Completed	Elementary/Secondary (0-12)		1-4 or 5+)		st of worki				done	160. Kind of Bi	usmess	industry	
15-0036 filed within 72 Hygiene. d other than "	lduc		2		Housev	vife					Own H			
	Be Co	17. Father's Name (First, Middle, J. Bruce Truet						Jeann	,	st, Middle, M	laiden Surname Titus	e)		
2121 hould be find Mental is marked	To	19a. Informant's Name/Relations			i		(Street a	and Numbe	er or Rural		ber, City or Tov			
and 2 sho ealth and sem 27 is iraumati		Thomas Roberts 20a. Method of Disposition	, Jr./ hu		20 Obs	serval	tion	Ct.,	, #10:	103, Germantown, MD 20876 Date 20c. Location - City or Town, State				
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.	1	1 Burial 2 X Cremation		rom State Ri	crematory or oth	er place) Park	:		1AY 12	2.2008		-	Park, MD	
altir rmit. P spartme sportar jury or	d	4 Donation 5 Other Sp 21. Signature of Funeral Service	Licensee		Cremato	ry ame and A	ddress o				P.A.			
		23a. Part I. Enter the disease, or		M01508	1933	Gist	t Av	e., I	LL, S:	<u>ilver</u>	Spring		20910 Approximate Interval	
Physician /Medical kaminer		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.				ayg, o.	2017 43 0411	0.000	piratory arro	50, 51156N, 51 TN		Between Onset and Death	
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequence o	of):									
cuted and transit	I Examiner	(Dicease or injury that initiated events resulting in death) Last	Due to (or as	a consequence o	of):									
O, the exe sician a	edical	X UNPENDED	AMENDED 23a PI	.27.perMF	La880 6/1	2/08 T	<u>т</u>							
Box 68760, he death certificate be executed y the attending physician and hed for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ne 23c. If yes, 1 Live 4 Preg	s, outcome of pregnancy e birth 2 Fetal death 3 Ectopic pregnancy Month Day gnant at time of death 5 Other (Specify)							·			
Bo the deat y the at	hys	Part II. Other significant condit	9011KI		Other (Specify)					22a Did to		-ib-sto to	the cause of death?	
s, P.O. Baires that the de	þ	Hypertensive o				idenying c	ause giv	en in Pait	·.				bably 4 🗸 Unknown	
ords aw requass beer	Completed							-	- 9	24a. Was a autops	sy		utopsy findings available completion of cause of	
Rectificate or, page	S	25. Was case referred to medical				26	Place	f Death (C	heck only	1 Y Yes 2	2 No	1 🗸 Y	es 2 No	
ion of Vital rending Physician: leath. tor: After this certif	o Be	examiner?	Hospital	Inpatient 2	ER/Outpatient		10	thor:	Nursing Ho		Residence 6	✓ Othe	er: Scene	
n of ding Pl	on: T	27. Manner of Death 1 X Natural 5 Pend		e of Injury h, Day,Year)	28b. Time of In			at Work?	- 1	. Describe h	ow injury occur	rred		
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Certification:	2 Accident Inves	stigation 28e Plac	ce of Injury - At h	ome, farm, street					Location (S	treet and Numl	ber or R	ural Route Number, City	
Div pital or ours aft filled in	Sertif	4 Homicide deter	d not be rmined (Specify))						or Town, St				
Divi	ical	(hysici an: To the be miner:On the basis											
To T	Medical	29b. Signature and title of certifie	and manner:				License						onth, Day,Year)	
2		Danne	Dinlin	D.			O.C.M	.E.			May 6, 20	80		
		30. Name and address of person Donna M. Vincenti, MI		se of death (Iten	-	Penn Si	treet 5	Raltimor	e MD a	1201	·			
St	ate	31. Date filed (Month, DayWear)		erstrar's Signat		r cill S	ucel, E		e, MD 2	. 1201		-		
Regist		mru 4,	- F000	Classics.	N. Ca	6462								

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death **Physician** Gladys Blanche Ritter 28,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) August 24,1922 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2XXF Yrs. Maryland 217-18-7319 Director 85 Usual Residence of Decedent a or 28a-f show t be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with r items 23a (iner must b 15608 Clear Spring Road 21795 USA Pages 1 and 2 should be filed within 72 hours after death nent of Heath and Mental Hygene. ant. If fiem 27 is marked other than "natural", or items 23 ury or other traumatic event, the Medical Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 XX If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 🐧 o Specify: Specify: 3√√Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ada Pearl Huffman Albert Kreps Kelley ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15536 Clear Spring Rd. Williamsport, Maryland 21795 Wilma Wilson -Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If it any Injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Greenlawn Mem. Park | May 1,2008 Williamsport, Maryland 4 Donation 5 ☐ Other (Specify) /ignatu Funeral Service Coense Ushorene A Maserally Home, P.A. 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition) 425 S. Conococheague St. Williamsport, MD 21795 Approximate Interval Between Onset and Death **Physician** METASTATIC disease or condition /Medical Due to (or as a consequence of): **Examiner** PLEURAL EFFUSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). The law requires that the death certificate be executed CHRONIZ LONET DIJENJE Exami sician and burial-trans Due to (or as a consequence of): physician a HY DRONEPHROSIS Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Dav 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed Were autopsy findings available prior to completion of cause of autopsy death? 1 ∐ Yes perform 2 No funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 ☑ Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: s after death filled in by within 24 hours at To the Funeral D

Certification: To 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

29b. Signature and title of certifier

29c. License number

10062006

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DN 10 A47 A160-WIREDM 251 MO 21740 E -KNTIETAM ST. HALIGHITOUR

State Registrar

APR 3 0

5H-4

DHMH 17 Rev 1/2001

Registrar

altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

29b. Signature and title of certifier

31. Date filed (Month, Day,

Molino MD

Year)

APR 3 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederiz

32. Registrar's Signature

MO51610

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician PM Josephine Richardson 8008 29 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimor Hospital Agnes Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Months 91 yrs. Yrs. 214-70-3106 Director Feb 13, 1917 Mary land Usual Residence of Deceden 10c. City, Town or Location la or 28a-f show t be notified at 10a. State 10b. County 10d. Inside City Limits 12☐Yes 2☐No Director Maryland Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or i any injury or other traumatic event, the Medical Examiner must be n 63888 Glenmore Avenue 21227 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Angelo Lamartina ၉ Jo<u>sephine DeMarco</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5017 Apache St., College Park, MD Virginia S. Pasta - Daughter 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery | 5/3/2008 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Freeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. H

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Immediate Cause (Final disease or condition resulting in death) Physician Shoc 4 days /Medical Due to (as a consequence of): Examiner necuronio Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due t (or as a consequence of) Physician/Medical Examiner burial-transit Due to (or as a consequence of): attending physician as the IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 ☐ Ectopic pregnancy for Month Dav Year 4□Pregnant at time of death 5 Other (specify) o detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Ves 2 □ No 24a Was an autopsy performed?

1 Yes 2 No Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification: To 1 X Inpatient 2 ER/Outpatient 3 DOA 0 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Attending Division 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 5 124 hours ar 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2.

OSEPHINE

31. Date filed (Month, Day, Year) State MAY 0 2 2008 Registrar

29b. Signature and title of certifier

900 Caton
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tao

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29c. License number

29d. Date signed (Month, Day, Year)

Avenue Baltimore Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 30,2008 **Physician** Charles Herbert Smith 8:15am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12326 Melling Lane Prince George's Bowie 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 10,1937 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1**⊠**M 2□F Cambridge, Mass. Hours Min. 029-28-1811 70 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at MD Prince George's Bowie 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12326 Melling Lane 20715 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 XYes 2 □ No If Yes, Give 1:954–81 Year or Date 1:954–81 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ZNo Specify: þ 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) USAF Ret. Senior Master Sqt. es 1 and 2 should be filed w of Health and Mental Hygie f Item 27 Is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Frazier Smith Jr, Marion Caroline Burleigh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Lois Smith/Wife 12326 Melling Lane Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Himportant: If Ite any Injury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Alexandria, VA. 4 Donation Metropolitan Crem. 5 Other (Specify) 2008 22. Name and Address of Facility Beall Funeral Home 21. Signature of Fundral Service Licensee 6512 NW Crain Hwy Bowie MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Colon Cancer resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the sequence of the Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 3□ DOA Certification: To 2 ☐ ER/Outpatient this After this funeral of Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending thours after death.

uneral Director: At ely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

completely within 2. State Registrar

31. Date filed (Month, Day, Year) MAY 0 2 2008

(Check only

29b. Signature and title of certifier

Martin Weltz 7525 Greenway Center, Greenbelt MD 20770 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D23743

29d. Date signed (Month, Day, Year)

May 1,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1220 PM 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel 1549 Farlow Ave. Crofton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 18, 1950 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 227-74-6525 1**⊠**M 2□ F 57 Yrs. New Jersey Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ "" any injury or other traumatic event." 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No VA. Fairfax Fairfax Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22039 USA 8305 Crosspointe Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 No 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Repro-Graphics College (1-4or 5+) Vice-President 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Santosusso John A. Scheller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5285 Holley Byron Road New York 14470 Renee A. Biedlingmaier/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2 Alexandria, VA. Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Puneral Service Licensee 6512 NW Crain Hwy. Bowie MD 20715 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final Physician Marths disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Mand 5 Nove 1 Yes 2 No 2 ER/Outpatient 3 DOA P 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1. Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State

31. Date filed (Month, Day, Year)

30. Name and addr.

29b. Signature and title of certifier

MAY 0 2 2008



ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

Re Sule 300 Amenolis Mi)

29d. Date signed (Month, Day, Year)

12008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month A_M Apri Carl Luther Sweeney 1:00 25 a008 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) WashingtonCounty Washington County Hospital <u>Hagerstown</u> 8. Date of Birth (Month, Day, Year) Nov. 11,1915 If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number Months Days Min. 1**X**□M 2□F Hours Maryland 92 214-10-5359 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐ No Washington County Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 1304 Pennsylvania Ave. 21742 12. Was Decedent Ever in U.S. Armed Forces? 1 (24 Yes 2 (11) 3 9 — If Yes, Give Year or Dates: 1942 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 🛣 No Specify. Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Railroad Conductor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" --- any injury or other traumatic events.

1 - State Registrar

10a. State

Directo

by Funeral

Completed

Physician

/Medical

Examiner

Funeral

Director

Physician /Medical Examiner

The law requires that the death certificate be executed attending physician and for use as the burial-tran signed by the a page certificate After this Hospital or Attending Director:

Division or Vital Records, P.O. Box 68760,

Be Hermie Mason Sweeney Malvin F. Sweeney ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16210 Fairview Rd. Hagerstown, MD 21740 C. Michael Sweeney-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 4-29-2008 Hill Cemetery Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North, Hagerstown, MD 21742 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEMONIA BILATERAL disease or condition resulting in death) Due to (or as a consequence of): DEEP VEINTHROMBOSIS LEG BILATERAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated 29b. Signature and title of certifier MD 251 E ANTIETAM ST, HAGERSTOWN, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHOTANI

JH-6+1

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30,2008 ear APRIL **Physician** 10:50A M GARY JOSEPH SANDERS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 XM 2 ☐ F Director 219-52-2149 57 June 28,1950 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified 1 TYPYes 2 □ No Director Maryland Frederick Emmitsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 126 East Main Street 21727 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, r than "natural", or items the Medical Examiner me 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. 8 Laborer Shoe Manufacturing traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H ant: If item 27 is marked oth Be Paul Sanders Cecilia Reese 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Teresa Sanders/ Wife 126 East Main Street, Emmitsburg, Maryland 21727 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Stauffer Crematorium Inc. 5/1/2008 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 21. Signature of Funeral Service Lig 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Days /Medical Due to (or as a consequence of): Examiner Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) physician Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 □ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Failure Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Inpatient Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes So No 2 ER/Outpatient 3 DOA Medical Certification: To this after death.

I Director: After this d in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Tanen

Maryland 21215-0036

Baltimore,

Records, P.O. Box 68760,

Vita

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Division

Frederica

29c. License number

MO51610

Tolino, MD

Michael

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrans Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 0 5 2008

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			For State Registrar	State of Maryla	•	artment of F rtificate of I		-	giene Reg. No.	308	16284
T	Physici	an	Decedent's Name (First, Middle, La	st)				2. Date of De		Year	3. Time of Death
1.0	/Medi	cal	Bruce 4a. Facility Name (If not institution, give		onesife		r Location of Death	April		2008 nty of Death	11:07 AM
18	Examir	ier	9316 Beth	el Road	1	Fred	derick		F	redei	rick
	Funeral Director		5. Social Security Number 6. 8	Sex 7. Age (In yi	rs. la <i>st birthday)</i> O ^{Yrs.}	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th y, Yea <i>r)</i> 27 , 1949	Count	ace (State or Foreign try) land
	P.		Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo	ocation		reb. 2	.7,1949		Od. Inside City Limits
	Maryla -f shov Ted at	to				erick					1 ☐ Yes 2 No
	ith the or 28a	Funeral Director	Maryland Freder 10e. Street and Number	ICK	rred	10f. Zip Code			10g. Citizen o	of What Count	try?
	eath w	eral	9316 Bethel R	oad 12. Was Decedent Ever in	IIS 13		21702			State	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Types 2 No 1	972-	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	Specity:	Rican, etc.)	Spe-	Black, White, e	
5-0	"natur	leted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	nation during most of work	king	16b. Kind of	f Business/Ind	lustry
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pu	iould be filed within I Mental Hygiene. I marked other than natic event, the Mariatic	Be	17. Father's Name (First, Middle, Last				18. Mother's Nam		Maiden Surn	name)	
Maryland	2 should I and Men Is marked aumatic	2	Norman Stonesi 19a. Informant's Name/Relationship		19b. Maili	ng Address (Street	Mary S		er, City or Tov	vn, State, Zip	Code)
_	es 1 and 2 soft Health ar item 27 Is		Norman Stonesi		her 182	Stonegat			ck, MD	21702	
Baltimore,	Pages 1 nent of He int: If iten		20a. Method of Disposition 1 X Burial 2 □Cremation 3 □	Removal from State	cemetery, cre	osition (Name of matory or other plac n Memoria	ce) ;	Date		on - City or To	wn, State laryland
altin	permit. Pag Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice	'y)		2. Name and Addre	15/2/2	2008 Stauffer			
Ä	permi Depa Impo any ir		1 jourtney	umtown Pi	ike, Fre	derick					
			23a. Fart1. Enter the (see st., or consider, or heart failure) List only Immediate Cause (Final	plications that ca set the de one cause in each line.	eath. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. HHIVOS Due to (or as a cons	equence of):	e Cordi	iovascu	lar	ISCA	se	Years
	Examiner	_	Se uentially list conditions.	b							
	d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence oi).						
50,	ificate be executed g physician and as the burial-transit	i Exa	resulting in death) Last	Due to (or as a cons	equence of):						
68760,	ficate to physical transfer to the transfer tran	edical		_d							
Вох	death certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pred 1 □ Live birth 2 □ Fe		∃Ectopic pregnancy	,			Date of deliver	
P.O. E	that the des ned by the at detached fo	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	of death 5	Other (specify)				Month	Day Year
	res that igned by be deta	by Ph	Part II. Other significant conditions	contributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use co	ontribute to th	e cause of death?
ord	w requir been si should b							1 🗆 🗎			
or Vital Records,	e la has le 2	Completed							osy rmed?	prior to con death?	psy findings available npletion of cause of
/ital	10 -	BeC	25. Was case referred to medical examiner?				26. Place of Deat	1 Yes h (Check only o	2No	1 □ Yes	2□ No
or/	Phys r this ral dii	၉	1 Ves 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury	☐ ER/Outpatier		4 □ Nursing H	ome 5 Resid		Other (Specify	/)
ion	Attending F r death. ector: After by the funera	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year) n		Wor	k? Yes 2 □ No	Edd. Deddillae i	ion injury occ	Mired	
Division	F de F	Certification:	3 Suicide 6 Could not b 4 Homicide determined		home, farm, str cify)	reet, factory, office		28f. Location (8 City or Tox		mber or Rurai	l Route Number,
	Hospita 4 hours Funeral ely fille	Medical C	29a. Certifier (Check only one) Certifying Plant Certifying Ce	nysician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, deat ination and/or in	h occurred at the tir	me, date and place, opinion, death occur	and due to the tred at the time,	cause(s) and date and plac	manner as sto be, and due to	ated. the cause(s)
	To the within 2	M	29b. Signature and title of certifier	1 1		29c. Licens	7107		1	ned (Month, L	_
•	11		30. Name and address of person who	eres ML) DM	F US	1111		April	29,	2008
(8+1		Alan Robrer, M	D DME15	West	74457	reet 1	Frede	rick	MD	2008
	Sta Registr		31. Date filed (Month, Day, Year) APR 3	0 2008 Registrates Sig	nature #	book					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** GERALDINE FITZWATER STARK 4:10 P M April 27 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days 1 ■ M 2 X F Hours 216-30-4022 75 Director 26 1932 Maryland Nov. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Rockville Director Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12909 Penrose Street 20853 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examina 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 🕱 No 3altimore, Maryland 21215-0036 Specify 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County Circuit Court Supervisor of Licensing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mathias Beulah Russell A. Fitzwater ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12909 Penrose Street, Rockville, Md. 20853 William R. Stark, Jr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Boyds Presby. Cem. 5/3/08 Boyds, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensage 22. Name and Address of Facility
Muriel H. Barber Funeral Home m-00470 P. O. Box 5038, Laytonsville, Md. 20882 23a. Par1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, styck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Immediate Cause (Final **Physician** Subarachnoid Hemorraghe Days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner for use as the burial-tran Due to (or as a consequence of): attending physician IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Alzheimer's Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No Severe Osteoporosis autopsy perform I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA npatient completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4.27.2008 Barbara RSM. D0065485 Suparuch, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910 1500 Forest Glen Road, Silver Spring, Md. Barbara Supanich, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Division or Vital Records, P.O. Box 68760, alor Attending Physician: The law requires that the death certificate be executed after clearb.	Phy /M Exa	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	132	
Director: After this certificate has been signed by the attending physician and din by the funeral director, page 2 should be detached for use as the burial-transit	rsician ledical aminer	Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Physic /Med Exam

Nhist		Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death				
Physicia Medic/		Nam Soon Shin				May	02 2008	11:05 a ^M				
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	h				
		Shady Grove Adventist Hospital			Rockville		Montg	omery				
uneral		5. Social Security Number 6. Sex 7. Age (In yrs. 1 ☐ M 2 ▼ F		y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You	ear) 9. Birt	hplace (State or Foreign untry)				
irector		220-96-8827	Yrs.			April 28,	1922	Korea				
3		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or	Location				10d. Inside City Limits				
sho ed at	5			011				1 □Yes 2 No				
28a-1	Director	Maryland Montgomery 10e. Street and Number		10f. Zip Code	ver Spring	10g. Citizen of What Country?						
a or		1135 University Blvd., #404		101. Zip 00de	20902	U.S.A.						
ns 23 must	Funeral	11. Marital Status 12. Was Decedent Ever in U.	S. 13	3. Was Decedent of H		ecify Yes or No-	rican Indian,					
iten Iner	ם	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No		If Yes, specify Cuba	an, Mexican, Puèrto	Rican, etc.)	Black, Whit	e, etc.				
al", ol xam	þ	3 🕱 Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	Asian				
atura cal E	ted	15. Decedent's Education	16a. Dec	cedent's Usual Occup	ation	16	b. Kind of Business/					
Medi "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life	ve kind of work done of DO NOT use retired	auring most of work d)	ang						
the th	ĕ	12		Homema	ker	Own Home						
vent	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Maiden Surname)						
arked atic e	은	Ki Chul Shin			N	lae Gook Lee						
is ma		19a. Informant's Name/Relationship (Type. Print)	19b. Ma	iling Address (Street	and Number or Run	ral Route Number, City or Town, State, Zip Code)						
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.	1	Audrey C. Im - Granddaughter		340 Q Street	, #12, NW,	Washington,	D.C. 20009					
f Iter		20a. Method of Disposition 20b. F 1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State	Place of Dis cemetery, ci	position (Name of rematory or other plac	ce)	Date 20	c. Location - City or	Town, State				
ant:			rt Line	coln Cremato	ry 05/0	6/2008 B	rentwood, M	a ry land				
ny Inj		21. Signature of Femeral Service Licensee		22. Name and Addrese Hines-Rinald		ome Inc.						
5 2 2		12 Kell / Type OF 2	P	11800 New Ha	mpshire Ave	nue, Silver	Spring, Ma	ryland 20904				
		23a. Part1. Enter the disease, or complication that coused the deat shock, or heart failure. List only one course on each line.	h. Do not e	enter the mode of dyir	ng, such as cardiac	or respiratory arrest	,	Approximate Interval Between				
sician		Immediate Cause (Final disease or condition resulting in death) Respiratory Failure										
edical		resulting in death) Due to (or as a consequence of):										
miner		Sequentially list conditions, if any, leading to immodiate b. Small Cell Undifferentiated Carcinoma Due to (or as a consequence of):										
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attending physician and for use as the burial-transit	хап	Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of:										
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atter for u	cian	in the past 12 months?	al death 3	B □Ectopic pregnancy □ Other (specify) _	′	23d. Date of delivery Month Day Year						
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sign d be	d by					1 ☐ Yes	2 No 3 P	robably 4 🖸 Unknown				
peen	Completed					Oda Wasan	045 144	to a finalism available				
2 0	ш					24a. Was an autopsy	prior to	utopsy findings available completion of cause of				
icate r, pa							performed? death? 1 Yes 2 X No 1 Yes 2 No					
certif	Be	25. Was case referred to medical examiner? Hospital: Hospital:		icet 3 DOA Oth	or:	n (Check only one)						
this al dii	P	1 ☐ Yes 2 ☒ No	ER/Outpati 28b. Time	IGHT 3 DOW	4 LI Nursing Ho		ce 6 Other (Spe	cify)				
After this certificate he funeral director, page	Certification:	1 ☑ Natural 5 ☐ Pending (Month, Day Year)	Injury	/ Wor	yat k? Yes 2 ∐No	28d. Describe how	injury occurred					
the /	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At h	ome farm			28f Location (Street	et and Number or R	ural Route Number				
Direction by	artif	4 Homicide determined building, etc. (Specif		o., 140.017, 000		City or Town,		arai rioute rumber,				
filled		29a. Certifier 1 X Certifying Physician: To the best of my kno	wledge de	ath occurred at the tir	me date and place	and due to the cau	so(s) and manner a	e stated				
To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examiner: On the basis of examina and manner stated.										
o th	Me	29b. Signature,and title of certifier		29c. Licens	e number	29d	. Date signed (Mont	h, Day, Year)				
,- 0		John Mana	10		D0064502		May 2, 200	8				
		30. Name and I dress of person while completed cause of death (Item	n 23a) (Tyno		_ 300 1302		-may 29 200					
		Brian Carpenter, M.D., 9901 Medical			ville. Marv	land 20850						
Sta	te				,,							
Registr		31. Date filed (Month, Day, Year) MAY 0.5 2008 32 Jegistrar's Signar	5 19	1000								

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	mer.	п	. Decedent's Name (First, Middle, Last)					_	2. Date of De	ath		V- 1	3. Time of Death	
	Physici /Medic		Adah Parker Strobell						Month) Da	2008	Year	4345A M	
	Examir	and a	a. Facility Name (If not institution, give street and number)		4b. City,	Town, or	Location	of Death		4c	. County	of Death		
			Doctor's Community Hospital		Lanh					Prince George's				
10	Funeral Director		. Social Security Number 6. Sex 7. Age (<i>In yrs.</i> 1	last birthday) Yrs.	If Under Months	1 Year Days	_If Under Hours	Min.	8. Date of Bit (Month, Da Jan 12	th ay, <i>Year</i> , 19	21_	Coui	place (State or Foreign ntry) fornia	
	and w			ty, Town or Lo	cation							1	10d. Inside City Limits	
	he Maryl 8a-f sho otified a	Funeral Director		ıham	10f. Zip				_	40- 0"			1 □Yes 2X No	
	with t	ğ	0e. Street and Number		10g. Citizen of V				ntry ?					
	eath	eral	7005 Nightingale Terrace 1. Marital Status 12. Was Decedent Ever in U	.S. 13.		706 dent of H	ispanic O	rigin? (Sp	ecify Yes or No			e - Americ	can Indian,	
<i>Adah</i> land 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Armed Forces? 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes, spec 1 ☐ Yes		in, Mexica Specify		ecify Yes or No Rican, etc.)		Blac Specify	k, White, Wh	etc. nite	
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Find	be fil Ital H ed oth	å	7. Father's Name (<i>First, Middle, Last</i>) Theodore Parker						s Name (First, Middle, Maiden Surname) rude Bell					
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	hould d Mel marke	은	19a. Informant's Name/Relationship (Type. Print)	19b Mailie	na Addrose	(Street				or City	or Town	State Zir	Cada)	
/// Maryl	d2s than than traur		Michael B. Donohue/Son		-				ural Route Number, City or Town, State, Zip Code) Glen Mills, PA 19342					
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∂. P.O. Box	sician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	Physician/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of o	aldeath 3□	⊒Ectopic pi ⊒ Other <i>(sp</i>		'				23d. Dat Mo	e of deliv	ery Day Year	
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Division or	ng Pl		27. Manner of Death 1	28b. Time o Injury	\mathbf{p}_{\bullet}	8c. Injur Worl	y at k?		28d. Describe	how inju	iry occurr	red		
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Ξ	or At after of Direct in by	Certification:	4 Homicide determined building, etc. (Speci	fy)	reet, ractory	, onice			City or To	wn, Stat	^(e) 700	5 Ni	al Route Number, ghtingale	
	To the Hospital or Attending Physician: The lwithin 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page		Hone 29a. Certifier 1 Certifying Physician: To the best of my kn	owledge, deat	h occurred	at the tir	ne, date a	ind place,	Terrac			_		
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	To the I within 2 To the I complet	Me	29b. Signature and title of certifier		290	c. Licens	e number			29d. Da	ate signe	d (Month,	, Day, Year)	
			I have MD			000	621	16		5	1.1	08		
			30. Name and address of person who completed cause of death (Iter	n 23a) (Type,	Print)					T-W				
_		1	YELLIT WORKNEH, 7705	Bei	lle P	oin-	+ Di	ive	Gre	enk	-e1+,	ME	20770	
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State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Charlotte 12 2008 3:08 A M F. Thomas May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner Carroll Hospice Dove House Carroll Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 □ X F Director 217-18-7299 86 Feb. 27, 1922 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nt: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1x Yes 2 No Director Maryland Westminster Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 108 Bond St U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: ģ 3 ⋈ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrl Maloy Fogle Hilda Pauline Yingling 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any Injury or other tr 1568 Spring Hill Dr., Hummelstown, PA 17036 Cherie I. Misas/ daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Meadow Branch Cemetery 5/18/2008 Westminster, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hartzler Funeral Home atharere New Windsor, MD 21776 310 Church St. 23a. Part1. Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Bleedino Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 X No nerform 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: $4 \square$ Nursing Home $5 \square$ Residence 6XXOther (Specify) hospice 1 ☐ Yes 2 No 2 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No I or Attendiate death. 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 - 12 - 08 29b. Signature and title of certifier D 51705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminstor, MD 21157 PANSURIUA malwim DR 349 22. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 9 2008 Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 29 2008 18:40 TATUM APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min 8. Date of Birth (Month, Day, Dec. 21 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** ^{Year)} 1926 North Carolina 1 □ M 2 🗷 F 244-32-4713 81 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 278 a marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 KNo Director Sandy Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20860 United States #D-10 17300 Quaker Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married White Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ≥ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) should be filt.

Ith and Mental Hy.

7 Is mark. 17. Father's Name (First, Middle, Last) Be Manie McBane Joseph Rav 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret T. Handler/Daughter 12725 Triadelphia Road, Ellicott City, Md. 21042 Saltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Alexandria, Virginia 5/01/08 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home Box 5038, Laytonsville, Md. P. O._ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDINI INFARCTION Physician 4 vte /Medical Due to (or as a consequence of) Examiner Se mentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☑ No Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by pe 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 10 No has 2□ No 1∏ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA ၉ 27. Mann Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury (Month, Day Year) 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

he Funeral Director: A pletely filled in by the ft. 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 ho

To the Fun

completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 2

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State Registrar GREGORY

31. Date filled (Month, Day, Year)

MAY 0

Rockville MANY/AND 20850

ess of person who completed cause of death (Item 23a) (Type, Print)

2008

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9-Earle Roland Wilhide, Sr. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min Months Days Hours 1**⊠**M 2□F Yrs. Nov. 15, 1918 Maryland 89 217-18-8238 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director Westminster Maryland Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 216 St. Mark Way 21158 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 XYes 2 □ No
1f Yes, Give
Year or Dates: 1944-46 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify. White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) employment service/office mgr | state government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Health and Mental H tant: If Item 27 Is marked oth Jury or other traumatic even Be Emma M. Stansbury Ross Reuben Wilhide 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Westminster, MD 21158 216 St. Mark Way Ethel E. Wilhide/wife saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Department Important: If any injury o 5/14/2008 nr. Union Bridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Mt. Union Cemetery 21. Signature of Funeral Service Licer 22. Name and Address of Facility Hartzler Funeral Home attarine 6 E. Broadway Union Bridge, MD 21791 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician a Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 ATRIAL FIBRILLATION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an perform Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. ■ Funeral Director: A 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hor To the Fune completely fi 0

> State Registrar

31. Date filed (Month, Day, Year) WAY 1 9 2008

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

30263

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Mican 00:49 61 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Battimore Sinai Https://www.scial Security Number Hospita If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 1 M 2 □ F Yrs. 01/15/2008 Director maryland Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Baltimore Funeral Director Baitimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or r 21207 Avenue Pages 1 and 2 should be filed within 72 hours after deal ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items: ury or other traumatic event, the Medical Examiner m. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. 11. Marital Status Black, White, etc. Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beivedere Balto, MD, ZIZIS HOST 1401 Avenue Nau Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 7/208 Bultimore, MD Hospital 0 4 □ Donation 5 ○ Other (Specify) HSpita 21. Signature of Funeral Service Licensee Since Hospital of Baltimore 2401W. Beivedere Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Immediate Cause (Final disease or condition resulting in death) **Physician** pneumocardium hai /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of Box 68760. physician Physician/Medical the as attending I 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No sate has been signed by the page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? /es 2/2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 20 No Inpatient P 1 ☐ Yes 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b, Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

Records, P.O. Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 oma Baltimore, no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital 0 2401 W. Belvedere Ave

State Registrar

31. Date filed (Month, Day, Year)
MAY 1 7 2008

					artment of Health and	Mental Hy	giene	recont
			= State Registrar Amend#23apxt.1PerPhys.PCC5-2-0	18cr <i>Ce</i>	ertificate of Death		Reg. No.	16294
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	/Medic		AlThea, Geneva,	0	colen	P 0	4c. County of Deat	
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e production of the second			Prince George's Hospital 5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday	If Under 1 Year If Under 24 H	rs. 8. Date of Birt	h 9. Bir	thplace (State or Foreign
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Ma	nd 2 s lith ar 27 is rtrau		LaKisha Ballinger - Daughter		7 - 75th Avenue,			
ā,	f Hearlitem		20a. Method of Disposition 20b.		position (Name of ematory or other place)	Date	20c. Location - City or	
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מ	Depared Important Important Information In		John J. Stewart.	17	4001 Benning Roa	ad, NE Wa	shington, I	T
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DHMH 17 Rev 1/2001

			For State Registrar	State	of Mar	yland / Depa <i>Cei</i>	artment of F rtificate of		Mental Hy	giene , Reg. No. ^C	2008	16295
	Physicia		Decedent's Name (First, Middle ANNIE	, Last)		WILLIAMSON	V		2. Date of Do Month APRIL	Dav	200 ^{Year}	3. Time of Death 6:32 A M
1	/Medic Examin		4a. Facility Name (If not institution SOUTHERN	, give street and no	ımber)	PITAL	4b. City, Town, o		ath		ounty of Death	RGE 'S
aring)	Funeral Director		5. Social Security Number 197–30–5049	6. Sex 1 □ M 2 X F		In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mil	8. Date of Bi (Month, Di SEPT	rth ay, Year) 17 19	9. Birthp	lace (State or Foreign try) CAROLINA
	e Maryland a-f show iffied at	ctor	Usual Residence of Decedent 10a. State 10b. County	E GEORGE		0c. City, Town or Lo					1	0d. Inside City Limits 1½∏Yes 2 ☐ No
	th with the 23a or 28 ist be not	al Director	10e. Street and Number 2415 KIRTLAND	AVENUE			10f. Zip Code 20747			-	n of What Coun	try?
5-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2∑ Marr 3 □ Widowed 4 □ Divorced	12. Was Dee Armed F 1 Yes If Yes, G Year or	orces? 2 ሺ No ive	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2ሺ No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or N erto Rican, etc.)		I. Race - Americ Black, White, Specify: BL	
0-61212	filed within 72 ho Hygiene. ther than "natur ent, the Medical I	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12) 11th	st grade completed) (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired ALYSIS T	during most of w d)	vorking	16b. Kind	of Business/Ind	·
/land ?		To Be C	17. Father's Name (First, Middle, THURMAN WILI	Last) LIAMS				18. Mother's N	ame <i>(First, Middle</i> E TOOTL)		urname)	
Mar	nd 2 salth ar 27 is 27 is r trau		19a. Informant's Name/Relations		R		ng Address <i>(Street</i> CIPRIANO					Code)
aitimore,			20a. Method of Disposition 1 □ Paurial 2 □ Cremation 4 □ Donation 5 □ Other (S		n State		sition (Name of matory or other place CEMETERY		Date 5/2008		otion - City or To	
Bait	permit. Page Department of Important: If any Injury or once.		21. Signature of Euneral Service	Licensee	int		2. Name and Addre	•	J. B AD LANDO	. JENK VER, 1	INS FUN MARYLANI	ERAL HOME D 20785
8/60,	Physician and physician and the pural-transit sthe burial-transit	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to Due to C.	o (or as a co) (or as a co)			•			20 /	Approximate Interval Between Onset and Death
O. Box 6	res that the death certificing by the attending be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		birth 2 nant at tir	Fetal death 3	Ectopic pregnanc Other (specify)	у		23	3d. Date of delive Month	ery Day Year
rds, P.	The law requires that ite has been signed by age 2 should be deta	by	Part II. Other significant condition	ons contributing to	death but	not resulting in the u	nderlying cause giv	en in Part I.				ne cause of death?
al Kecords,	(Q LL	Completed							24a. Wa aut per 1 Yes	opsy formed?	24b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of 2 No
n or vital	Phy r this ral di	on: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin	Hospital: 128a. Date (Mo	Inpatient e of Injury nth, Day	28b. Time o	f 28c. Inju	ner: 4 □ Nursinç ry at rk?	Peath (Check only 3 Home 5 ☐ Res 28d. Describe	sidence 6		ýy)
Uivision	tenc leath tor: the	Certification:	2 Accident investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	e of injury ding, etc.	- At home, farm, str (Specify)		Yes 2□No	28f. Location City or To	(Street and own, State)	Number or Rura	al Route Number,
	Hospital 4 hours Funeral ely filled	Medical Ce		Examiner: On the		my knowledge, deat xamination and/or in						
)	To the I within 2 To the I complet	Me	29b. Signature and title of certifie	All			29c. Licens	se number	P	29d. Date	signed (Month,	Day, Year)
R	3			295/00	Ro	of For	Print) facush-	, Jan m	0 207	44		
2	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 2 2008		Registrar'	s Signature						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland / Depa <i>Cer</i>	artment of Health and I tificate of Death	Mental Hygiei Reg.	6 000	16296
	Physici	an	Decedent's Name (First, Middle, Last)				Day Year	3. Time of Death
	/Medi Examir		Margaret Ann Walsh 4a. Facility Name (If not institution, give stre		4b. City, Town, or Location of Death		4c. County of Death	2;10 A. M
	Examili	iei	St. Vincent Care (Emmitsburg		Frederic	s.
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year II Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birthp	lace (State or Foreign
	Director		579-66-7320 Usual Residence of Decedent	93 Yrs.		Nov. 22,	1914 Mar	yĺand
	nyland how		10a. State 10b. County	10c. City, Town or Lo			1	0d. Inside City Limits
	8a-f s	Director	MD Frederic	k Emmitsbu	rg,			1X Yes 2 □ No
	with the or 2		10e. Street and Number		10f. Zip Code		Citizen of What Cour	itry?
	death ms 23	nera	335 South Seton A	Was Decedent Ever in U.S. 13. V	21727 Vas Decedent of Hispanic Origin? (S	pecify Yes or No-	J.S.A. 14. Race - Americ	an Indian,
5-0036	within 72 hours after death with the Maryland ene. than "neturel", or items 23e or 28e-f ehow he Medical Examerer must be notified at	by Funeral	1 ⊠ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	Yes, specify Cuban, Mexican, Puert Yes 2\(\overline{\Omega}\) No Specify:	o Rican, etc.)	Black, White, Specify: Whit	
7	72 hc	Completed	15. Decedent's Educat (Specify only highest grade c	ion 16a. Deced	ent's Usual Occupation kind of work done during most of wor IO NOT use retired)		. Kind of Business/Ind	dustry
7	within ene. than	Juno	Elementary/Secondary (0-12)	College (1-4or 5+)	·		ligious Co	
ק ק	il Hygie other	Be Co	17. Father's Name (First, Middle, Last)	College 5+ Nur		Da: ne (First, Middle, Maid	ughters of Hen Sumame)	Charity
yland	should be nd Mental n marked c	To B	John Walsh		Delia .	Joyce		
Mar	C1 cg == @	1	19a. Informant's Name/Relationship (Type Mother St Sister Camilla Har	Print) 19b. Mailing	g Address (Street and Number or Ru			
a)	1 and Health Health Sem 27	1	Sister Camilla Har 20a. Method of Disposition		S. Seton Avenue		rg, MD 21 Location - City or To	.727
altimor	Pages nent of int: if it		1 Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposed Streem Cosed Provincia	Indriger other place) 1 House 5/6/		mitsburg,	
Dail	permit. Pages Department of important: If it eny injury or o		21. Signature of Funeral Service Licensee	22.	Name and Address of Facility My 10 W. Main Street	ers-Durbor	aw Funera	1 Home
H		1	23a. Part1. Enter the disease, or complicat shock or heart failure. List only one	ions that caused the death. Do not ente				Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	advanced	Vascula A	emention	_	Interval Between Onset and Death
	Examiner		0	Que to (or as a consequence of):	a Varrula 1	Julane		208
	sit ad	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				3/1
	icate be executed physicien and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence oi):	na			Joys
00/0	ysicier buri	dical	U d. □					V
00	ing ph		IF FEMALE:					
S O	ath ce attendi for use	Physician/M	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of delive	ry Day Year
	the de by the	hysic	1 ☐ Yes 2 KNo 9 ☐ Unknown	4 Pregnant at time of death 5 Unknown	Other (specify)			,
ָר נְיֻ	uires that signed t id be det	۵	Part II. Other significant conditions contrib	outing to death but not resulting in the uni	derlying cause given in Part I.		o use contribute to th	e cause of death?
200	s beer s beer s shou	olete				24a. Was an		osy findings available
ב ה	To the Hospitel or Attending Physicien: The law requires that the death centif within 24 hours efter death. To the Funcial Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be deteched for use as	e Completed	25. Was case referred to medical			autopsy performed 1 Yes 2	prior to con death?	npletion of cause of
>	ysicie is cent direct	To B	examiner? 1 Yes 2 No	oital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	0.1	th (Check only one)	6 MOther (Specific	1
S	ng Ph fter th ineral		27. Manner of Death 1 ANatural 5 Pending	28a. Date of Injury 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe how in		/
2	tendi death. tor: A the fu	ertification:	2 Accident investigation		M 1 Yes 2 No			
2	itel or Al	Certif	4 Homicide determined	28e. Place of Injury - At home, larm, stree building, etc. (Specify)	et, lactory, office	281 Location (Street City or Town, Sta	and Number or Rurai ate)	Route Number,
	• Hosp 24 hou • Fune etely fil	Medical	29a. Certifier (Check only one) (Check only one) (Check only one)	an: To the best of my knowledge, death On the basis of examination and/or inve and manner stated.	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stand due to	ated. the cause(s)
	within To the compl	Me	29b. Signature and title of certilier	11 100	29c. License number	29d. [Date signed (Month, L	Day, Year)
	WIL) Ulla	Laurell M	D18705		5/21.08	
	1		30. Name and address of person who comp		·	· · · · · · · · · · · · · · · · · · ·		
	Stat	e	A. L. CARROLL, /	32. Registrar's Signature	SETON AVENUE EN	MITSBURG,	MD. 2177	-7
	Registra		MAY 0 5 20	B-	Touch ,			

Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Physici		Registrar 1. Decedent's Name (First, Mic	ddle, Last)						2. Date of Dea Month	th Day	Year	3. Time of Dea	ith
/Medi		LEONARD JOH	N WILLIAMS						APRIL	26	2008	10:25	M
Examir		4a. Facility Name (If not institut	tion, give street and nun	nber)		4b. City, Town,	or Location of	of Death		4c. County	of Death		
	**	27950 TRED AV		7 4 // /-	- A le indle de col	EAS	If Under	24 Hre	8. Date of Birth		ALBOT	ace (State or Fo	reian
Funeral Director		5. Social Security Number 578–18–8921	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. Ia 82	St birtnaay) Yrs.	Months Days		Min.	(Month, Day DEC 12	, Year)	Coun		
		Usual Residence of Decedent							DEC 12.	, 13-5			
how		10a. State 10b. Cour	nty	10c. City,	Town or Lo	cation					10	0d. Inside City Li	
natural", or items 23a or 28a-f show lical Examiner must be notified at	Director		ALBOT		EAS	STON						1 Yes 2	INO
or 2 be no	Dire	10e. Street and Number				10f. Zip Code			1	Og. Citizen of \		try?	
is 23g must	Funeral	27950 TRED A		dent Ever in U.S	13	2160		nin? (Spe	ocify Yes or No-		USA ce - America	an Indian.	
r item Iner		11. Marital Status 1 ☐ Never Married 2X M	Armed For	rces? 2 ∐ No		Was Decedent of If Yes, specify Cul		n, Puerto	Rican, etc.)	Blac	ck, White,	etc.	
al", ol	þ	3 Widowed 4 Divorc	If Yes Giv	re		1 □ Yes 2 🗶 No	Specify:			Specify	Y: WHI	TE	
natur	Completed	15. Deced	dent's Education thest grade completed)			dent's Usual Occu		t of worki	na [16b. Kind of B	usiness/Ind	lustry	
than "	nple.	Elementary/Secondary (0-12	2) College (1	-4or 5+)	life.	kind of work done DO NOT use retire						_	
Hygien ther the		17 Fether's Name (First Midd	5 (for Least)	<u> </u>		ATTORNEY	1	ar'e Name	(First, Middle,	REAL		E	
ntal F ed ot	Be	17. Father's Name (First, Midd LAWRENCE EDW.							LOUISE 1		ne)		
nd Mer marke matic	ှင် .	19a. Informant's Name/Relation			19b. Mailir	ng Address (Stree					. State. Zip	Code)	
f Health and Mental Hygiene. item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		ANNE W. PETO:			7591	TRED AV	ON CI	RCLE	, EASTO	N, MD 2	1601	·	
item othe		20a. Method of Disposition			ace of Dispo	sition (Name of matory or other pla	ace)	C	ate	20c. Location -	City or To	wn, State	
nent of h int: If ite iry or of		1 ☐ Burial 2 X Crematio 4 ☐ Donation 5 ☐ Other		State		E CREMAT	i	TR 4	/29/2008	3 STEVE	NSVIL	LE, MD	
Department of Important: If any injury or once.	1	21. Signature of Funeral Servi	ice Licensee	\	22	2. Name and Addr	ess of Facilit	ty				Messes se	A
2 E E 5		JOHN R	MERCI	ERON		200 S. HA						nome, r	.A.
		23a. Part1. Enter the disease, shock, or heart failure. L	, or complications that ca list only one cause on ea	aused the death. ach line.	Do not ent	er the mode of dy	ing, such as	cardiac o	or respiratory arr	rest,		Approximate Interval Betwee Onset and Dea	
ysician		Immediate Cause (Final disease or condition	_a. <i>E</i>	Vd Smi	ch	romic Ob	Truck	W 1	Vonwork	> Dijoi	11	- HAV	u i
Medical xaminer		resulting in death)	Due to (or as a conseque	ence of):				/		_/	/	
ullilite	_	Sequentially list conditions,	b	of as a conseque	ara es est.				CATION APPRO	1/	VAMINE		_
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 May 5:24 A M Theresa Winchester /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 😿 F 69 January 25, 1939 Ohio 269-34-7960 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 921 Cherokee Trail 21701 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 2 Married Specify: White 1 ☐ Yes 2 🕱 No Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 Is marked ot Rita Machovina Albert Detorre ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 921 Cherokee Trail, Frederick, Maryland 21701 Eugene Winchester / Husband Baltimore, permit. Pages.
Department of Her
Important: If iter
'-'ury or o' 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date May 7, 2008 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State Smithsburg Crematory 4 □ Donation 5 □ Other (Specify) Smithsburg, Maryland 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 21. Signature of Funeral Service Licenses 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRO VASCULAR ACCIDENT **Physician** DAYS /Medical Due to (or as a consequence of): Examine LUNG CANCER METASTATC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed sician and burial-trans Due to (or as a consequence of) ng physician as the burial Physician/Medical attending I for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy page ; certificate 1□ Yes 2 12 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 ☑ No P 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending Investigation 1 Matural (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

Box 68760 P.O. Division or Vital Records,

or Attending Physician: within 24 hours after occ...

To the Funeral Director: Aft To the Hospital

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

Medical

State

29d. Date signed (Month, Day, Year)

ND

DOD 61410

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAFFAR

MAY 0 5 2008

32. Registrar's Signature

Sol Toll House AVE, FREDERICK, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician May 12° 2008 2:00 amM Anthony Edward Wolk /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 7937 Edgewood Farm Road Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | NOV 111, 1930 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral №** M 2□ F Pennsylvania 169-24-9450 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Maryland Frederick Director Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21702 U.S.A. 7937 Edgewood Farm Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. XXYes 2 □ No ff Yes, Give 1948-1952 Year or Dates 1948-1952 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Ind 2 should be filed within 72 alth and Mental Hygiene.
27 is marked other than "n: Iraumatic event, the Medi Elementary/Secondary (0-12) College (1-4or 5+) US Government Engineer/Research 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Hajduk Anthony Wolk 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any Injury or other trau 7937 Edgewood Farm Road, Frederick, MD 21702 Mrs. Ida B. Wolk, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Stahlstown Cemetery May 16, 2008 Stahlstown. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funetal Service Licentee 22. Name and Address of Bastford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final a spiration Physician disease or condition resulting in death) /Medical Due to (or as a con equence of) Examiner body Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Il-transit Due to (or as a consequence of) physician s the burial Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 22 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ို 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ustin 009689 ourve

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAY 1 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



TOHY A 1/em 08-03722 UN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

IK UNK		State of Maryland / Dep		it of Health a e of Death	nd Menta		200	8 1630
Physicia	_	legistrar 1. Decedent's Name (First, Middle,Last)	runcate	or Deaur		2. Date of Death		3. Time of Death
edical Examir		Tony	All	len		Month [May 15, 200		1959 hrs
£		4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital		4b. City, Town, Baltimore	or Location of I	Death	4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthda		ear If Under 2	24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birt	hplace (State or
Director		210 02 1/30 4	2	Yrs. Months Da	ays Hours	Min. 5-28	3-1955 Foreign Co.	untry) MD
ying.	ŀ	Usual Residence of Decedent	y, Town or l	Location				10d. Inside City Limits
nd show :	اۃ	MD N/A Ba	ltim	ore				1 X Yes 2 No
Maryla 28a-f d at or	g	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Cour	ntry?
th the 23a or	٥	221 N. Spring Court	10 Ta	2 14/ 12	2123	? (Specify Yes or No-	U S A	can Indian, Black,
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral Director	11. Marital Status 1 X Never Married 2 Married Armed Forces?	J.S. 18	If Yes, specify Cub	an, Mexican, F	Puerto Rican, etc.)	White, etc.	
fter de	핈	3 Widowed 4 Divorced If Yes, Sive Year or Dates:		1 Yes 2 X	No specify:		Specify:	Black
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0036 within 72 hours after death with the Maryland jiene. rer than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	흶	Elementary/Secondary (0-12) College (1-4 or 5+) 11th grade N/A		ama 1 arra á	1		unemplo	yed
5-00 ed with lygiene other	Completed	17. Father's Name (First, Middle, Last)	<u>j un</u>	employed	18.Mother's	Name (First, Middle, Mi	aiden Surname)	
21215-0036 suld be filed within 7 Mental Hygiene, marked other than tevent, the Medica	B	Marion Allen				Ella Wil		7:- 0-4-)
e, MD 21215-0036 I and 2 should be filed within 72 hours after Health and Mental Hygiene. Tiem 27 is marked other than "natural", r traumatic event, the Medical Examiner	۱٩	19a. Informant's Name/Relationship (Type, Print)					oer, City or Town, State	
e, M and 2 Health item 2			. Place of D	Disposition (Name of or other place)	cemetery,	Date	20c. Location - City or	Town, State
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Baltimo permit. Page Department Important: injury or oth	İ	21. Signature of Funeral Service Licensee		22. Name and Addr		March F/		
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Physician /Medical		failure. List only one cause on each line.		•				Between Onset and Death
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60, e be executed ysician and burial - transit	edical	UNPENDED AMENDED						
68760 certificate l anding phys		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pre	egnancy 2	Fetal death	3 Ectopic	pregnancy	23d. Date of deliver Month	y Day Year
Box 6876(death certificate the attending physelor in the base the b	icia	past 12 months?		Other (Specify)				
	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but no	resulting in	the underlying caus	e given in Par	t I. 23e. Did tol	bacco use contribute to	the cause of death?
P.(<u>a</u>	•					2 🗸 No 3 🗌 Pro	bably 4 Unknown
Cords, law requir has been s	etec		-		-	24a. Was a		utopsy findings available completion of cause of
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f Vid	의	examiner? 1 Ves 2 No 1 No 27. Manner of Death 28a. Date of Injury			niury at Work?	28d. Describe h	Residence 6 Other	er:
on of anding Photh. Ith. It. After to the funeral	ë E	1 Natural 5 Pending May 15, 2008	1807 h		Yes 2	No Subject shot	į.	
Division of Vital Hospital or Attending Physician: 24 hours after death, Funeral Director: After this certifiely filled in by the funeral director,	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Street	home, farm	n, street, factory, offic	ce building, etc	28f. Location (S or Town, S 1800 North Po	Street and Number or R tate) ort Street, Baltimore,	ural Route Number, City
Di To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier 1 Certifying Physician: To the best of my knowly one) 2 Wedical Examiner: On the basis of examination	edge, death	occurred at the time	, date and place	ce, and due to the cause	e(s) and manner as sta	ted.
To t To C	Medical	and manner stated. 29b Signature and title of certifier			ense number		29d. Date signed (M	
		Pati an-Blee.	- O	0.	C.M.E.		May 16, 2008	
\mathcal{V}		 Name and address of person who completed cause of death (Its Patricia Aronica-Pollak MD. Assistant Medica 	l Examin	ner 111 Penn	Street, Ba	ltimore, MD 2120	1	
St Regist	ate rar	31. Date filed (Manth, Day, Year) 32. Fegistrar's Sign.	ature	Soules				
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year ASH TON 10150AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOS PITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10M 2□F Days Months Hours Director 219-12-8885 Maryland 83 Feb 20 1925 Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits Md. 1 ☐ Yes 2 No Director Anne Arundel Co. Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be 1618 Bedford Rd. 21061 USA Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 Divorced White "natural" Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Rep Electrical Products other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown **Blanche** ဂ္ unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a Diane Ashton, wife Bedford Rd. Glen Burnie, Md. 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 5/19/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Gonce Funeral Service P.A. 4001 Ritchie Hgwy. Baltimore, Md. 21225 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HEMIC resulting in death) /Medical Due to (or as e consequence of): Examiner ETABOLIC Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, Examine The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 4□Pregnant at time of death ed by the 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. neral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours at To the Funeral D Hospital

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AANA BEBU, HARBOR HOSPITAL, 360/ 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature MAY 2 0 2008

PHYSICIAN

29c. License number

TH HANDUER STREET

29d. Date signed (Month, Day, Year)

3001

8-03660 Keith L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 16303

Ceith Lee Amilian		or State	Ole	ate or ma.	J. C	Certi	ficate of	Death			- 12	D 1 - 15	Reg. No		13	3. Time of Death
Physician		nistrar Decedent's Name	(First, Middle	e,Last)								Date of D	Day	Year		1438 hrs
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4	48	. Facility Name (if		n, give street ar	nd number)		1	Luthervi		ocation or i	Dodin			Baltimore	e Coun	nty
		1521 York R			17.4-	e (In yrs. las	t hirthday)	If Under 1		If Under	24Hrs.	8. Date o	f Birth (MI	N/DD/YYYY	g. Birth Foreign	place (State or
Funeral	5.	Social Security N	umber	6. Sex				Months	Days	Hours	Min	Sent	. 13	, 1957		ntry) MD
Director		217-60-4		1 X M 2	F	50	Yrs	·		L		БОРТ		, - ,		10d. Inside City Limits
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/land	힑	MD 0e. Street and Nu		imore_				10f. Zip C	ode				10g. (Citizen of Wh	nat Coun	try?
Mary Mary	Director			1						21093					USA	Ladian Block
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5-0036 iled within 77 Hygiene. d other than the Me lical	Completed		·	a Last)			Dece.	WOLK	1	18.Mother	's Name	(First, Mi	ddle, Mai	den Surnam	e)	
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2121 2121 Juld be fi Mental marked ic event,		19a. Informant's N	lame/Relation	nship (Type, Pr	nt)		19b. Mail	ing Address	(Stree	et and Num	nber or R	ural Rou	te Numbe	r, City or To	wn, State	e, Zip Code)
MD 2 id 2 shou lith and M m 27 is r	\vdash	John F.				er	94	Engli	sh	Run C	lir.	Spar	KS,	Oc. Location	1 - City o	r Town, State
and 2 and 2 lealth item 7 trau	ı	20a Method of Di	isposition			206.	Place of Disp crematory or	other place)	ie or ce	metery,		Date,				re, MD
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Baltimore, MD 21215-0036 permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at ouce.		4 Donation 21. Signature of	Secol Secol	Licensee			22	Name and emmon	Addres Fun	s of Facilit eral	Home	w.of	Dul	aney	Vall	ey, Inc.
Ba Pern Imp Inju		23a. Part I. Enter	Wieli		Flag1	e	10	emmon O W. P	ado	nia R	Road cardiac o	T1mc r respira	ory arres	t, shock, or l	2109 neart	Approximate Interval Between Onset and
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aiiiiiei		or condition resu	Iting in death		(or as a co	onsequence	01).									
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SiOl Atten r death	oy me	2 Accide	•	Investigation	28e. Plac	e of Injury - A	At home, farn	n, street, fact	ory, offi	ce building	g, etc.	28f. I	ocation or Town,	(Street and I State)	Number 0	or Rural Route Number, C
Division tal or Attendi us after death.	filled in by the tune	3 Suicid		Could not be determined	(Specify)											
		29a. Certifier	Certify	ing Physician:	To the bes	st of my knov	vledge, death	occurred at	the tim	e, date an	d place,	and due t	o the cau	ise(s) and m e and place,	anner as and due	s stated. to the cause(s)
the H hin 24	completely	(Check only one)	Medica	at Examiner: Or	the basis d <u>manner s</u>	of examination	on and/or inv	estigation, in	i iiiy op			od di alo				to the cause(s) (Month, Day, Year)
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. /	-	30. Name and	address of	person who cor	npleted cau	se of death	(Item 23a)	111 Pen	n Stre	et Ralt	imore	MD 21	201			
Ø		Tasha	Greenberg	MD. As	sistant	nedical Ex	xammer	TIT PELL	1 300	Joi, Dan						
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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 16b per fh, g879,05/20/08dhb

Certificate of Death

Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:25 PM Deborah BlackWell 13 08 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice DVVSOV if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day 06 22 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 215.54.0814 Months 1 □ M 2 KF 58 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County MA 1 Nes 2 No MD BaltinTore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or edical Examiner must be r 1503 USA Burnwood Koad by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry City
Baltmore County 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Cara Teacher Schools St years permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie. Important: If Item 27 is marked other th any injury or other traumatic event, the once. 12th arade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sephino Bowman Monroe ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Window Mill, MD 21244 8007 150 Tarver Parks Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 05/17/108 Windsor Mill, MD King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral 6VCS 21. Signature of Funeral Service Licenses 8728 Liberry Road Randall Stown MD 21132 Vaughn C. Ssee 23a. Part1. Enter disease, or complications that caused the death. Do not enter the mode of dying, swall as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** sears disease or condition resulting in death) /Medical Due to (or as a consequence of), Examiner Sequentially list conditions, if any, leading to immediate line for the line of the line o Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Day Year 5 Other (specify) 9 Linknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No Blackwell 24a. Was an autopsy performed2 res 2 No 1⊟ Yes Division or Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. R. Ley C. B.M.C. 678, N-Chiles St. Balto and 21207

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Registrar

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fb e880 6-5-08 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Rosina Blount 1910 PM May 12 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. | DEC. | DEC. | 20 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F MD Director 62 1945 218-58-2980 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director BALTIMORE MD 10g, Citizen of What Country? 10e. Street and Number 10f. Zip-Code Funeral 1207 GREENMOUNT AVE. 21202 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than is 1 and 2 should be filed with of Health and Mental Hygiene. item 27 is marked other than DAYCARE PROVIDER PRIVATE 10TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CATHERINE WALKER ပ LEROY AVERY other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1610 ASHBURTON ST., BALTIMORE, MD 21216 SHARON McMAHON 20b. Place of Disposition (Name of Pages 1 20a. Method of Disposition Date 207 12 ation City of The ST. cemetery, crematory or other pi permit. Pages 1 Department of H Important: If ite any Injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/21/2008 | BALTIMORE, MD 21224 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part 1. Enter the disease of 21231 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on early line. shock, or heart failure. List ediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Subarachnoi **Physician** Hemorrhage 2 wee /Medical resulting in death) Due to (or as a consequence of) **Examiner** Cardiac Minutes Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or) and burial-trar Due to (or as a consequence of) Box 68760, nding physician Physician/Medical certificate be use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy gned by the atten be detached for in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 🗌 No 1 Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury or Attending 1 ☐ Yes 2 ☐ No М Accident completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier 1 Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD May 12, 2008 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gu 600 North Wolfe St, Baltimore, MD, 21287 Shiveen 31. Date filed (Month, Day, Year) MAY 2 0 gistrar's Signatur 32 State 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 9, 5:00 A^M MAY 2008 RUTH ELIZABETH BROOKS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 4117 ELDERON AVE. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F Yrs. MAY 7, NC 89 Director 220-38-9556 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show any: If item 27 Is marked other than "hatural", or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 X Yes 2 No Directo BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4117 ELDERON AVE 21215 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: BLACK 1 ☐ Yes 2 ☒ No Specify: Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL 12TH NURSE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELIZABETH DAVIDSON EDWARD DAVIDSON မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4117 ELDERON AVE., BALTIMORE, MD 21215 CLARADINE BUTLER/CAREGIVER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1050 SUNSET BEACH RD. permit. Pages
Department of
Important: If it
any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/15/2008 CROWNSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part1. Enter the disease or complica shock, or heart failure List only one Immediate Cause /Final Approximate Interval Between Onset and Death used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that the death certificate be executed that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Year ō Month Day 5 Other (specify) the detached 9 ☐ Unknowh ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has certificate 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 2 ER/Outpatient 3 DOA 1 Inpatient 2 this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t Certification: 1 Natural
2 Accident Injury (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical

P.O. Division or Vital Records, Hospital or Attending To the Hospital within 24 hours a To the Funeral I

Box 68760

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) 20

re and title of certifier

29b. Sign

30. Name ar

2008

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 08

dress of person who completed cause of death (Item 23a) (Type, Print)

00 W egistrar's Signature

ASTINGTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 17 9:08 p^M May 2008 Biedermann /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Gilchrist Center Towson Baltimore 8. Date of Birth (Month, Day, Year) OCT 19 1923 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Poland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F 84 071-28-4779 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show tems 23a or 28a-f shov iner must be notiffed at 1 □Yes 2XNo Director MD Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7080 Cradlerock Way USA 21045 Funeral death 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 In It Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ö 1 ☐ Yes 2 🗓 No Specify. Maryland 21215-0036 Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature any injury or other traumatic event, the Medical any enter traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and 2 should be filed within lealth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 Mechanic Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Biedermann Victoria Templehof 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pauline Biedermann - Wife 7080 Cradlerock Way, Columbia, MD 21045 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition of t 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 5/19/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H, Williams 22. Name and Address of Facility Cremation Society of Maryland, Inc. Hull 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death LUNG CANCER WITH Immediate Cause (Final MOS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed nding physician and use as the burial-transi Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Vear in the past 12 months? Day 5 Other (specify) signed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performe yes 2 this certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 💆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of eath
1) Natural
2 \(\text{Accident} \) 28a. Date of injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blod/Balto MD

State Registrar

31. Date filed (Month, Day, Year)

MAY 2 0 2008

32 Registrar's Signature

Le Specific

9:08

JONAS

PEDERMAN,

Box 68760. P.0. Division of Vital Records, After this of funeral direction

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RRAINE 1930 BRICK HOUSE Month. **Physician** 01 01 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 21,1928 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 T MA 214-26-7786 80 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, I'm Martinal Environment to the page. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No by Funeral Director Anne Arundel Linthicum 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21090 U.S.A. 636 Timothy Drive 12. Was Decedent Ever in U.S. Armed Forces 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 fi If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: White 3 Nidowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Techstyle Mfg. Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Alma Clairmont Arthur Leo Brunelle ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) niece Mrs. Elaine McGee 7514 Harmans Road Harman, MD 21077 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State y 19, 2008, Meadowridge Mem. Pk. Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Svs. 21. Signature of Funeral Service Licensee M00918 2nd Avenue, S.W. Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation I hours after death. uneral Director: Af ely filled in by the fur 1 ☐Yes 2 ☐ No 2 🗆 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi who completed cause of death (Item 23a) (Type, Print)

A ENTH WM 445 DEFENSE 31. Date filed (Month, Day, Year) MAY 2 0 32. Ragistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 13ª **Physician** 2008 May 9:30 Ам Shawn Belverud /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles 5423 Harvist Fish Place Waldorf 8. Date of Birth (Month, Day, OCT 17, Birthplace (State or Foreign Country) Arizona If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Year) 1972 1 X M 2 □ F 601 32 5080 35 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County r than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at MD 1 ☐ Yes XX No Charles Waldorf Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5423 Harvist Fish Place United States 20603 by Funeral hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Mes Elementary/Secondary (0-12) College (1-4or 5+) 12 Ret U.S. Navv Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jerome E. Belverud Fave Dell Keller ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tara Elizabeth Belverud (Wife) 5423 Harvist Fish Place, Waldorf, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Removal from State Lee Crematory May 16, 2008 Clinton, MD 5 ☐ Other (Specify) 4 ☐ Donation 21. Signature Funeral Ser 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d 00153 Alexandira Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e. ch line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ne /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No the 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 212 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes XX No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide

Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Krishan Mathur, M.D. 3500 Old Wahington Road Suite 102, Waldorf, Md.

31. Date filed (Month, Day, Year) 6 2008 Registrar

29b. Signature and title of certifier

29a. Certifier

Medical



and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** MA 18,2008 CHOPIC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE Lenter If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕦 F Months 216-58-4526 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Pres 2 No "natural", or items 23a or 28a-f sh edical Examiner must be notified 16 more **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black Specify Completed by 3 Widowed 4 Divorced 77 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tomemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Health and Mental tem 27 is marked o ျှ 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code) Ba 16. Lermaine 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) permit. Pages 1 Department of H Important; If ite any Injury or ot once. ⊠Burial 2 □Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one of use on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one of Immediate Cause (Final STROKE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ussass or Injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 RESPIRA 2 No 1 🗌 Yes 3 Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1∏ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 2 ☐ Accident Injury s after dec. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063327 Pairow H. Wowertimo7 19,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

MAY 2 0 2008

DHMH 17 Rev 1/2001

32. Registør's Signature

GIZAW WOLDEHLUDT, MD 2434 W. BELVEDERE AVE, BALTIMORE, MD 24215

		ľ	1 = For State Registrar	State of N	Maryland	•	artmen tificate				-	giene Reg. No.		16311
	Physici	an	Decedent's Name (First, Middle, Las		11011						2. Date of Dea Month	ath Day	/ Yea	3. Time of Death
	/Medic		GEO:	RGE E	BUCK						May 18	3 2	800	8:50 a ^M
	Examin	er	4a. Facility Name (If not institution, give		r)		* * * * * * * * * * * * * * * * * * * *		Location o	of Death			County of De	ath indel Co.
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	Funeral Director		5. Sociat Security Number 6. Security Number 11 6. Security Number	MM 2□F 7.7	Age (In yrs. la 81	as <i>t birtngay)</i> Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da August	y, Year)	1926	irthplace (State or Foreign Country) Maryland
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	Ba-f e	Funeral Director	Md. Anne Arun	del Co.	G1	en Bur								
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	er de Item	nue	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Deceder Armed Forces 1 Yes 2	s? _	5. 13.	Yas Deced	erfy Cuba	n, Mexican	gin? (Spe n, Puerto l	cify Yes or No Rican, etc.)		Black, Wh	
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Õ	be filed within 72 hours after deeth with the Marylan ital Hygiene. id other than "natural", or items 23a or 28a-1 ehow event, the Madical Examinet must be notified at	Completed by	15. Decedent's Ed	ucation		16a. Dece	dent's Usua	al Occupa	ation		-	16b. K	ind of Busines	
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p	al Hygie I other vent.	Be	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)	
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Maryland 21215-0036			19a. Informant's Name/Relationship (7	-							I Route Numbe			
	s 1 and f Health Item 27 other tr		Eunice L. Buck,	wife	205 01	7642			venue		en Buri			
O			20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from Stat	te ce	ace of Dispo	natory or o	ther plac						or Town, State
Baltimore,	artmen ortant: injury		4 Donation 5 Other (Specify		Ce	dar Hi			-		2/08	ват	to. Ma:	ryland
Bal	permit. Page Department of Important: if any injury or once.		21. Signature of Funerat Service Licen	soo Limbel sel	n Ha				s of Facilit	Gor	ice Fund			
			23a. Part1. Enter the disease, or comp	dications that caus	ed the death				ie He				d. 212	25 Approximate
			shock, or heart failure. List only of Immediate Cause (Final	one cause on each	line.	^		·	9, 00000	00.000				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	en		nce	<u>ہ۔</u>						20 montes
	Examiner		1	Due to (or a	as a consequ	zence or):								
	_	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or t	as a consequ	ience of):								
	ate be executed sysicien and he burial-transit	Examiner	Cause (Disease or injury that initiated events	c										
ó	exer ien ar urial-t	EX	resulting in death) Last	Due to (or a	as a consequ	ience of):								
3760,	hysici	Ical		d										
68 v	eath certifica attending ph for use as th	Med	IF FEMALE:									-		st the second
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. tf yes, outcom 1☐Live birth	2 Fetal	death 3[Ectopic pr					- 17	23d. Date of o Month	lelivery Day Year
0	The law requires that the death certifica Ne has been signed by the attending ph page 2 should be delached for use as th	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		eath 5	Other (sp	ecity)						
P.0	that the de led by the a detached t		Part II. Other significant conditions co	ontributing to death	but not resu	alting in the u	nderlying c	ause give	en in Part I.		23e. Did t	obacco (use contribute	to the cause of death?
Records,	uires tha signed id be de	d by		•			, •				10	Yes 2	£140 3□	Probably 4 Unknown
Ö	w requir been s should	Completed									24a. Was	an	24h Wara	autopsy findings available
Re	The lav	Ę.									autop	osy rmed?	prior t death	o completion of cause of ?
Vital	iclan: Th certificate rector, pag	C	25. Was case referred to medical						26 Place	of Doath	1 ☐ Yes	21 No	1 1 1 1	es 2 No
>	Physiclan: this certific ral director,	ToB	examiner?	Hospital:	atient 2 🗆 8	ER/Outpatier	nt 3□ DC	Oth			ne 5 Resi		6 ∏Other (Si	pecify)
0	iding Physician: th. After this certifical funeral director, p		27. Manner of D-ath	28a. Date of Ir		28b. Time o		8c. Injun	/ at		28d. Describe			,,
Ö	Attending or death. ector: After by the fune	atlo	1 Natural 5 Pending 2 Accident investigation		say / bai/	mjury	М		Yes 2	No				
Division	or Attano efter death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	289. Place of	Injury - At ho etc. (Specify	me, farm, sti	eet, factory	, office			28f. Location (. City or To			Rural Route Number,
0	ital o irs eft rel DI		14 194 194											
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical Exaπ	ysician: To the be iner: On the basis										
	thin 2 the the	Med	29b. Signature and title of certifier	and manner	stated.		290	Licensi	a number			29d. Da	te signed (Mo	nth Day Year)
	7 × × 0			ou 1	1.7		250	\mathcal{L}	295	05		Ma	M 19	2008
			30. Name and address of person who	nompteted source	death (No-	23a) /Tuna	Print\	ע	ر _ا د	-)	7.000		0 "	
			V 11 101 1	completed cause of	305	Host	المازد	1 2	~. G	ler	Bun	rie	, M	ue to the cause(s) inth, Day, Year) 2008 D. 21061
	Sta	ite	31. Date filed (Month, Day Year) MAY 2 0	32. Regin	strar's Signat	ture	1.	, .	-					
	Registi		MAYZU	ZUUB	Market .	19.	1004	1						

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

death with the Maryland 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at Director 3939 Roland Avenue by Funeral 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If them 27 is marked other than "nature." 1 Never Married 2 Married Baltimore, Maryland 21215-0036 3 Nidowed 4 □ Divorced Completed Elementary/Secondary (0-12) 17, Father's Name (First, Middle, Last) Be John Brawner ပ 19a. Informant's Name/Relationship (Type. Print) Bernard R. Brawner, Jr. (Son) 20a. Method of Disposition 1 ☐ Burial 2 💢 remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Aicensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-trar Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 No 2 27. Manner of Death 1 Natural Certification: 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific T2138946 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 LAISON MEMORIAL HOSPETAL, SMEHAL 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

MAY 2 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4:01 p Sylvester Burrell May 12, 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore **Timonium** Stella Maris If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Min. Hours 1 □ M 2 □ F Months No. Carolina Mar 28, 1956 217-64-6143 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 No N/A **Baltimore** Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A 3528 6th Street 21225 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Ye ar or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Self Employed Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dora Burrell Nathan Burrell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3528 6th Street Baltimore, Maryland 21225 Melvin Burrell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 DeBurial 2 ☐ Cremation 3 ☐ Removal from State 05/20/08 Lansdowne, Maryland Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 7.6.11 23a. Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death th. Do not enter the mode of dving, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

ပ္

Funeral

Director

show

Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f st any Injury or other traumatic event, its needles Texaniner must be notified any Injury or other traumatic event, its needles and proper.

with the Maryland

death

filed within 72 hours after

Pages '

Saltimore, Maryland 21215-0036

P.O. Box 68760.

Records,

Division of Vital

SLYVESTER BURRELL

2008

Examiner Physician/Medical detached \$ Completed Be

the attending physician and hed for use as the burial-tran is been signed by the should be detached page 2 s funeral director,

certificate has Physician: After this or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the Hospital

Certification: To filled in by Medical

25. Was case referred to medical 1 ☐ Yes 2 X No 27 Manner of Death 1 X Natural 2 ☐ Accident

3 ☐ Suicide 4 ☐ Homicide 29a. Certifier

29b. Signature and title of certifie

(Check only one)

5 Pending

6 ☐ Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28h Time of

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🚺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

24a. Was an

autopsy

1 ☐Yes 2XINo

Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

2 🗆 No

			_										
30.	Name	and address	of	person	who	completed	cause	of	death	(Item	23a)	(Type,	Prin

TARIQ MAHMOOD

2300 DULANEY VALLEY RD. 32. Registrar's Signature

TIMONIUM, MD 21093

26. Place of Death (Check only one)

DHMH 17 Rev 1/2001

State Registrar 1 - State Registrar

1. Decedent's Name (First, Middle, Last)

216-24-9484

5877 Race Road

1 □ Never Married 2 □ Married

11. Marital Status

filed within 72 hours after death with the Maryland must be notified at "natural", or items 23a other traumatic event, the Medical Examiner

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

The law requires that the death certificate be executed and Box 68760. attending physician as the P.0. cate has been signed by the page 2 should be detached Division or Vital Records, this certificate has

by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Black 1 ☐ Yes 2 ☐ No Specify: Specify: 3 □ Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Rosewood State Hospital Elementary/Secondary (0-12) College (1-4or 5+) **Nursing Assistant** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Henson Francis Howard Griffin 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5877 Race Road Elk ridge, Maryland 21075 James M. Brown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Md. 05/16/08 **Baltimore National Cemetery** 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 21. Signature of Funeral Service License 23á. Part - Enter de disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYCCAROLAL Lou Due to (or as a consequence of): nreny ORDINA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Tes 2 🗌 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Yes 2□ No Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Certification: To hours after death.

Ineral Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MORRICK KUHN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 2 0 2008 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Elizabeth M. Brown

7. Age (In yrs. last birthday)

Yrs.

10c. City, Town or Location

5877 Race Road

6. Sex

Howard

1 □ M 2 🔀 F

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

Elkridge

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

21075

Days

10f. Zip Code

Howard

U.S.A.

14. Race - American Indian,

Black, White, etc.

3. Time of Death

11:00 a

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

County Maryland

Reg. No.

May 10, 2008 ear

4c. County of Death

10g. Citizen of What Country?

2. Date of Death

8. Date of Birth (Month, Day, Year) Sep 10, 1927

Elkridge

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death May 16, **Physician** 2008 10:14 AM Henry Birney Bedell, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Bethesda

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 27,] Montgomery Suburban Hospital Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 □ F 92 018-09-2498 1916 Massachusetts Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits or items 23a or 28a-f show ust be notified at Director 1 ☐Yes 2 X No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4111 Leland Street 20815 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No th and Mental Hygiene. 7 is marked other than "natural", or items traumatic event, "In Wolfer! Eventing in 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11, Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates: 1 ☐ Never Married 21 Married Baltimore, Maryland 21215-0036 <u>چ</u> 1 ☐ Yes 2 TNo Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Company 4 Steel Executive permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event once. 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry B. Bedell Jean Henry ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Upland Rd., Unit G-4, Baltimore, MD 21210 Janet E. Bedell / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. May 22, 2008 | Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M00896 7557 Wisconsin Ave., Bethesda, MD 20814-3501 Approximate Interval Between Onset and Death 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Intracranial Hemorrhage /Medical Due to (or as a consequence of) Examiner Traumatic Left Subdural Hematoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine No burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician 0 Physician/Medical the as attending properties for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? δ Fall 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Pacemaker, Artificial Heart Valve 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of certificate death' 1 □Yes 2 □No 1 ☐ Yes 2 🔀 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 🖾 No May 13, 2008 07:00 2 X Accident Fell at home 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide 4197 LeTand Street Chevy Chase, Maryland 20815 Home 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

State

10 14 Am

5/16/08

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Natasha P.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2008

0

32. Register's Signature

Haag,

29c. License number

8600 Old Georgetown Road, Bethesda, Maryland 20814

29d. Date signed (Month, Day, Year)

May 17, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 17, **Physician** 2008 21:36 Christine E. Bruno /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, April 18, 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F **Director** 1922 167-14-6891 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20816 5014 Sangamore Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates: 1 Never Married 2X Married 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other this any injury or other traumatic event, II we Federal Government Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Krist Ralph J. Quarry ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5014 Sangamore Rd., Bethesda, Maryland 20816 Ralph J. Bruno / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland Gate of Heaven Cemetery May 21, 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M00896 7557 Wisconsin Ave., Bethesda, MD 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 month Immediate Cause (Final **Physician** Malignant Pleural Effusion disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Metastatic Breast Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami sician and burial-trans Due to (or as a consequence of): 68760, attending physician for use as the buria Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 Tyes 2 X No. ö been signed by the should be detached 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 □ Yes 1 ☐Yes 2 ☐ No Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🖾 Inpatient 2 ER/Outpatient 3 DOA Certification: To ō After thi funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred or Attending Division 1 X Natural 5 Pending investigation I hours after death.
uneral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D37891 May 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Rajvanshi, M.D., 121 Congressional Lane, #409, Rockville, Maryland 20852 31. Date filed (Month 32. Registrar's Signature State 0 2008

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

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CHRISTINE

RUND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 10e per th, g879, 05/20/08dhb.

Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Month Physician Teg URR IMALI /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death County of Death **Examiner** - Hospida HOS SEASOMS angala If Under 1 Year | If Under 24 Hrs. 9. Birthplace Country) 8. Date of Birth (Month, Day) Social Security Number 7. Age (In yrs. last birthday) (State or Foreign **Funeral** Months Days Hours 217.20.346 1**X** M 2□ F MD 80 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exprimer must be notified at MD Baltimone 1 □ Yes 2 XXNo Director Oak 6 WILLIAN 10e. Street and Number 2121 Windsor Garden Lane 10f. Zip Code 10g. Citizen of What Country? 21207 USA Vymasor Apt. 425C Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 72 hours after 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: Black \$ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas Elementary/Secondary (0-12) College (1-4or 5+) Electrician 8 Electric 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental William I Cum Pearl Haynie ည Informant's Name/Relationship (7)/pe. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 si Department of Health an Important: If item 27 is 1 any injury or other trau Adams 3503 Hillsmere Road nariene Baltimore MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ■ Burial 2 □ Cremation 3 ☐Removal from State avings Mills, MD 801 4 ☐ Donation 5 ☐ Other (Specify) Garrison Signature of Funeral Service Licensee ghn C. Greene Fundal Sovices Jayan indalistown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) P.O. 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed s certificate has b irector, page 2 st 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform of Vital 1 □Yes 2 -NO 1 ☐ Yes 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Detrier (Specify) NOSPICE 2 No this 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral 27. Manner of Death 1 Matural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation I hours after death.

'uneral Director: Af
ely filled in by the fur 1 ☐Yes 2 ☐No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of persor who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

25

B

Month, Day, Year) 2 0 2008 MO

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	oraro or maryiar		tificate of		mornar rij	Reg. No.	2008	16318
	Dhyaisi		1. Decedent's Name (First, Middle, La	ist)				2. Date of Do	eath Day	Year	3. Time of Death
	Physici /Medic		BETTIE	COLEMAN				MAY	17		7:00 P ^M
	Examir	ner	4a. Facility Name (If not institution, give	,			r Location of Deat	h	4c.	County of Death	
J* 1			2806 SPARROWS P			EDGEN If Under 1 Year		0.0	11:	BALTIME	
	Funeral Director		5. Social Security Number 6. S	I M 2 K I F	Yrs.	Months Days	Hours Min.	(Month, D	rtn ay, Year)	Count	**
			212-28-0871 Usual Residence of Decedent	77				11/19	/1930)	MD
vland	MOL THE		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10	d. Inside City Limits
N E	a-f s	횽	MD BALTI	MORE	EDGEMI	ERE					1 XYes 2 □ No
5-0036 72 hours after death with the Maryland	ral", or items 23a or 28a-f show Extrailiter must be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Count	ry?
th w	23a		2806 SPARROWS P	OINT ROAD		2121	.9			USA	
r dea	or Items ?	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or Note to Rican, etc.)	0-	14. Race - America Black, White, e	
35 saffe	o.	by F	1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give		□Yes 2 No	Specify:	,		Specify:	
1 5-0036 72 hours aft	ene. than "natural", te Medical Exp	pe pe	3 Widowed 4 Divorced	Year or Dates:	160 Donos	lant's Hausi Ossur	ation			BLA	
. 27 u	giene. r than "natul if e Medical	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Give	tent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	16D. KI	nd of Business/Ind	ustry
CZLZD		omp	Elementary/Secondary (0-12)	College (1-4or 5+)		CEACHER	2)		T	EDUCATION	
□ □	Hyg it,	Be C	17. Father's Name (First, Middle, Last	<u>-</u> -	1 3	LEACHER	18. Mother's Nar	ne (First, Middle			
d be	@ @ a	To B	TAS P. STATHAM				BETT	Y CRAGW	ΑY		
ary shoul	th and Mer 7 is marke traumatic	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street	and Number or R	ural Route Numi	ber, City or	r Town, State, Zip	Code)
, M	alth a 27 is er tra		CALVIN STATHAM/	BROTHER	122	6 DAMSEL	ROAD	BALTIMO	RE. M	ARYLAND	21221
• •	프호늄		20a. Method of Disposition	20b. F		sition (Name of natory or other place		Date	r	cation - City or Tov	
Saltimor bermit. Pages	Department of Important: If its any Injury or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification	Themoval from State		MEMORIAL	i	24-2008	D.A	T TTMODE	MARYLAND
<u>;</u>	Departmen Important: any Injury once.	li	21. Signature of Funeral Service Licer							N & SONS	F.H., INC.
	B a a		James 9.	moton						E, MARYAL	
			23a. Part 1. Enter the disease, or com stock, or heart failure. List only	plications that caused the deat							Approximate Interval Between
Ph	ysician		Immediate Cause (Final disease or condition	. ()	ar A	rrhyth n					Onset and Death
	Medical		resulting in death)	Due to (or as a conseq		Thy III	110				-
(E)	caminer	Ш	e management en anne	b. Hyperten	SIVE	Heart	i) iscase	೭			15 xrs
/ 0		ner	Securately list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq							
ecute	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
, o e e	urial-		resulting in death) Last	Due to (or as a conseq	uence of):						
oorou, ficate be ex	ohysic the b	Medical		d							
X O	ding p		IF FEMALE:	00-16							
ath ce	attend for us	Physician/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna	l death 3 □	Ectopic pregnanc	у		2	23d. Date of deliver Month	ry Day Year
) §	the the	ysic	1 □ Yes 2 DNo 9 □ Unknown	4 ☐ Pregnant at time of o	leath 5∟	Other (specify) _					,
That t	ed by detac		Part II. Other significant conditions of	contributing to death but not res	ultina in the un	derlving cause giv	en in Part I.	23e. Did	tobacco u	se contribute to the	e cause of death?
aw requires t	sign d be	d by	α	LUCOV		,,		1	Yes 2	□ No 3 □ Proba	ably 4 Unknown
i requ	been	etec									
e law	has je 2 s	Completed						24a. Was	psy	prior to con	sy findings available pletion of cause of
ָה הַ הַּ	ficate r, pag							1 □Yes	2 No	death? 1 ☐ Yes	2 □No
VIL	certii	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dea	E 3			
2 4 2	r this ral di	_유	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient 2 □	ER/Outpatien 28b. Time of	1 OLI DOX	4 LI Ivarsing r	lome 5 Res 28d. Describe	_	Other (Specify)
ding	h. Afte fune	ţ	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	Injury	28c. Injur Worl	yai ⟨? Yes 2 □No	Zad. Describe	now injury	y occurred	
Affen	deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be		me, farm, stre			28f Location	Street and	d Number or Rural	Route Number
2 5	Dire d in b	Certification: To	4 ☐ Homicide determined	building, etc. (Specif	y)			City or To	wn, State))	
spita	neral	a C	29a. Certifier Certifying Ph	ysician: To the best of my kno	wledge, death	occurred at the til	me, date and place	e, and due to the	e cause(s)	and manner as st	ated.
e Ho	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medical Exar	niner: On the basis of examina and manner stated.	ition and/or inv	estigation, in my o	pinion, death occi	urred at the time	, date and	place, and due to	the cause(s)
To th	withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	e signed (Month, E	Pay, Year)
	,		Riber Dost			D 3	39660		Ma	24 19,	2008
.		- 1	- 100 COA.				INDO			1	

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Point Rd. Baltimore, MD 21219 State Registrar

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner with the Table 2010s.

		-										
		Pleas	se Type or I							gible.		
	For State Registrar		State of	Maryland		artment of F rtificate of	lealth and M <i>Death</i>		giene Reg. No. (000	16319	-
n ai	1. Decedent's Name	. (,	c, Last)					2. Date of De Month	ath Day 1 9	Year	3. Time of Death 2:00 P M	
er	4a. Facility Name (1)	0	give street and num			1	r Location of Death	0	4c. Co	ounty of Death	,	
	5. Social Security N	7345	6. Sex 1 ☐ M 2 ☐ F	7. Age (16) yrs. lasi 53	<i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	h y, <i>Year)</i> -1954	Cos	hplace (State or Foreign untry) N.C.	
	Usual Residence of 10a. State	Decedent 10b. County		10c. City. T	own or Lo	ncation					10d. Inside City Limits	
tor	MD	TOD. County	N/A	,	timo						1 Tyes 2 No	
Direc	10e. Street and Nur	mber				10f. Zip Code			10g. Citizer	n of What Co	untry?	
<u>a</u>	5234 S	avbro	ok Road			2	206		U.	S A		
ne	11. Marital Status	w1 ~ = 0	12. Was Dece Armed For	dent Ever in U.S.	13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	. 14.	Race - Amer Black, White		
Be Completed by Funeral Director	1 ☐ Never Marri 3 ☐ Widowed			2 X No e		1 ☐ Yes 2 ☐ No	Specify:		Sp		lack	
eted		15. Decedent	's Education st grade completed)		(Give	dent's Usual Occup	during most of work	ing	16b. Kind	of Business/I	Industry	-
ошы	Elementary/Seco 12th q	- 1_ /	College (1	-4or 5+) N/A		DO NOT use retire Letary	d)		Cat	on Ma	nor N/H	
	17. Father's Name (` '	,				18. Mother's Name			rname)		
မှ			rd Richa				Pinkie					_
	19a. Informant's Na	ame/Relationsh	nip (Type. Print)		19b. Mailir	ng Address (Street	and Number or Run	al Route Numb	er, City or To	own, State, Z	Zip Code)	
	Patrice	Cres	t-Daught		5234		ook Road	Balt				
	20a. Method of Disp		3 □Removal from S	cem	e of Dispo etery, crea	osition (Name of matory or other pla	ce)	Date	20c. Locat	tion - City or	Town, State	
	4 □ Donation				enmo	ount Cer	n 5-20	-2008	Balt	o, MD		
	21. Signature of Fu	ineral Service I	Licensee		22	2. Name and Addre	ess of Facility Ma	arch F,	∕H Ea	st		
	Canda	ai h	Wiz Fa	olote		1101 E	. North	Avenue	e Bal	to, M	4D 21202	_
	shock, or hea	rt failure. List	complications that ca only one cause on ea	aused the death. ach line.	Do not ent	ter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Immediate Cause (disease or condition resulting in death)		a. CHF								month	
	100atting in deatti)		Due to (or as a consequer	ice of):							
er	Sequentially list coi	nditions, nmediate	b. 17500 Due to (or as a consequer	ice of):						years	

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed

After this certificate

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical

IF FEMALE:

3 ☐ Suicide

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☑ No

	Due to (or as a consequence of)	:
_d		
		_
23c.	If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death	

HAM

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___

23d. Date of delivery Month

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

autopsy performed?

2 - No

9 LI Unknown	
Part II. Other significant condition	ons contributing to death but not resulting in the underlying cause given in Part I
no shoma	

art II. Other significa	int conditions contributing to dea	th but not resulting in the	underlying cause given i	n Part I
Ps ma				
2				

24a. Was an 1□ Yes 26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 Mo						
		spital: 1 ☐ Inpatient	2 🗆	ER/Outpatient	3 🗆 [OOA
7. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28a. Date of Injury (Month, Day Ye		28b. Time of Injury	М	28c.

lc	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 D	OA Other:	Wursing H	ome	5 ☐ Residence 6 ☐ Other (Specify)
	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 E I No.	28d.	Describe how injury occurred
	28e. Place of injury - At he building, etc. (Specif	ome, farm, stree			2 🗆 110	28f.	Location (Street and Number or Rural Route Number, City or Town, State)

4 ☐ Homicide	determined	building, etc. (Specify)
9a Cartifiar	1 Certifying Physi	cian: To the best of my knowledge, death occurred at the

29a. Certifier	1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(Check only one)	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the caus and manner stated.
One)	aliu mannei stateu.

29D.	Signi	ature	anu	ille or c	Serinie	71		
			1er	e	Ke	uz	mo)

6 ☐ Could not be

29c. License number 1) 31295" 29d. Date signed (Month, Day, Year) 5/19/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 Al Charles St 16icesz

72112

Tousai

21201

State Registrar

31. Date filed (Month, Day, Year) MAY 20 2008



Director

Mildred

5. Social Security Number

10e. Street and Number

10a. State

MD

201-22-4445

Usual Residence of Decedent

Union Hospital

10b. County

Cecil

Jane

6. Sex

1□M 2XF

Crabtree

7. Age (In vrs. last birthday

78

10c. City. Town or Location

Perryville

Funeral Director

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. signed by the a d be detached f funeral director. After this after death

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Medical Examiner must be notified at 414 Harford Street 21903 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 2 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Cooper Mildred Ensminger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rommel T. Crabtree - Son 801 Cedar Lane, Bel Air, MD 21015 Department of Health Important: If Item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metro Crematory, Inc. 5/19/2008 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Steven H. 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD Williams 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** WEEN /Medical Due to (or as a consequence of): Examiner BLEGDING GASTROINTESTINAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner SHINGLI physician and s the burial-trans CHRONIC RENAL INSUFFICIENCY Due to (or as a consequence of) Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2√No 24a. Was an s certificate has b lirector, page 2 sl 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Naturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P. V. Newyow ? D0065733 16/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. PULA 10 RAD 118 NORTH STREET SUITE 313 ELKNN, MD 2192 31. Date filed (Month, Bay, Year) 32. Registrar's Signature State Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Elkton

Days

Months

10f. Zip Code

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

Min.

2. Date of Death

8. Date of Birth (Month, Day, May 18,

May

3. Time of Death

1:46p

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2X No

Pennsylvania

2008

4c. County of Death

10g. Citizen of What Country?

Cecil

16

1929

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** Year 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A 5. Social Security Number **Funeral** Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) Days 1 M 2 M 860 215-12-5110 Director 103/192 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 🙀 No Director MD BALTIMORE OVERLEA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 541 ST. PATRICK RD 21206 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ XNo Specify. Specify: WHITE 3 X Widowed 4 ☐ Divorced Year or Dates: other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **8TH** HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK WISNIEWSKI MARGARET PEARCE ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 541 ST. PATRICK RD BALTIMORE, MD 21206 JEROME CUSIMANO-SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: if it any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State LAKEVIEW CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 5/20/08 SYKESVILLE, MD 21 Sign dur Funeral Se e Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 23a Part1. Enter the sist shock, or heart failed Immediate ause (Final disease or condition resulting in death) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) Yes 2 No 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause 23e. Did tobacco use contribute to the cause of death? þ 3 □ Probably 4 □Unknown 1 🗌 Yes 2 🗆 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed. has Hospital or Attending Physician: 25. Was case referred to examiner? 26. Place of Death Check only one) Other: 44 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient 3□ DOA Certification: To 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manne eath 28b. Time of 28d. Describe how injury occurred After 1 Platural 5 ☐ Pending investigation 1 🗌 Yes after death 2 Accident completely filled in by the 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L l 🗹 CertifyIng PhysicIan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

me and address of person who completed cause of death (Item 23a) (Type, Print)

324Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Walter P. Dent Jr. 19, May 2008 9:00 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4720 Water Park Drive Unit R Belcamp Harford If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1909 Months Days Hours IXIM 2□F 98 217**-**07-4967 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland | Baltimore Kingsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7212 Sunshine Avenue 21087 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Fire Extinguisher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter P. Dent Sr. Winifred Maupin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter P. Dent III, Son 605 Hollen Road Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 05/19/08 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 Months disease or condition resulting in death) Metastatic Cancer - Unknown Primary Due to (or as a consequence of) Sequentially list conditions, if my leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to for as a consequence of: Due to (or as a consequence of) IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 KNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 X Natural 5 Pending investigation

the death certificate be executed attending physician and for use as the burial-transi P.O. Box 68760, ned by the a detached for Division of Vital Records, been signe should be To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Examine Physician/Medical þ Completed Be ၉ Certification:

Medical

Physician

/Medical

Examiner

Funeral

Director

show

Directo

Funeral

þ

Completed

if Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar traust be notified at

the Maryland

death with

Pages 1 and 2 should be filed within 72 hours after

jo **__** Department of Important; If It any injury or conce.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of ce

29a. Certifier

2 Accident

4 Homicide

3 ☐ Suicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number D35012

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin LYNLH

31. Date filed (Month,

6 Could not be determined

32 Registrar's Signature

Box 68760, P.0. Division of Vital Records.

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registrary Signature

Roder

Yorco

Deburah 31. Date filed (Month, Day, Year) H45931

Mousterstown MD

14th

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 16324 State of Maryland / Department of Health and Mental Hygiene Marquerite Ellen Donovan Certificate of Death Rea. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ Month Day May 13, 2008 1100 hrs Ellen Donovan Marguerite Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Towson 521 Epsom Road #1C 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Hours Months Davs 03 - 01 - 1947218-46-2299 Maryland Country) Director 61 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Yes 2 X No Baltimore Towson Maryland 28a-f show other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21286 521 Epsom Road #10 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes White imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after of nent of Health and Mental Fygiench and It and Mental Fygiench and It and Mental Fygiench and Health and Mental Fygiench of the returnal of or other traumatic event, the Medical Examiner II. Yes 2 X No specify: 3 X Widowed Divorced Yes, Give Yea \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Retirement Home Nursing Assistant 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Angela A. Jakubowski Henry A. Markowski Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) timore, MD 490 Torbert Road Fawn Grove, PA 17321 Mary Mignini - Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 05-20-2008 Garrison Forest Vet. Cem. Owings Mills, Maryland portant: Domation 5 Other Specify: 22. Name and Address of Facility 5305 Harford Road 21. n e of Funeral Service Licensee Leonard J. Ruck, Inc. Baltimore, Maryland 21214 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. Death 'Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit executed Physician/Medical UNPENDED AMENDED attending physician for use as the burial -The law requires that the death certificate be Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown the 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. \$ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? certificate has Yes 2 No e Hospital or Attending Physician: 124 hours after death. Funeral Director: After this certifi. 26 Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other; Hospital: Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27 Manner of Death Certification: 1 V Natural 1 Yes 2 No Director: Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 Suicide or Town, State) determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie May 14, 2008 O.C.M.E.

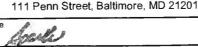
10

31. Date filed (Month, Day, Year) MAY 2.0

Jack Titus MD.

30. Name and address of person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner 32. Registrar's Signature



State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Davidson ason 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 488-78-3241 37 Director June 24.1970 Missouri Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic execution. 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits St. Charles Director Missouri 1 ☐ Yes 2 K No Lake St. Louis 10e, Street and Number 10f. Zip-Code 10g. Citizen of What Country? 32 St. Cloud Court 63367 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏲 No If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify Specify: White \$ 3 TWidowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert ၀ Davidson Sherry Reagan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Downey (Grandmother) 32 St. Cloud Court, Lake St. Louis, Missouri 63367 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 05-17-08 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 30 E. Fort Avenue, Baltimore, Maryland 21230 and Point . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death runnediate Cause (Final disease or condition resulting in death) dystunction **Physician** Cardiac 2days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed attending physician and I for use as the burial-trai resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live birth 2 ☐ Fetal death ☐ Pregnant at time of death in the past 12 months? Ectopic pregnancy Month Day Year 5 Other (specify) n signed by the at uld be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2 No 3 Probably 4 Unknown 1 Tyes certificate has been sig lirector, page 2 should I Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 2 ☑ No 1 Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 2 No Hospital: 1 🗌 Yes npatient 2 ER/Outpatient 3 DOA 9 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director. After this completely filled in by the funeral di . Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 🗌 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) the Hospital 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainly as a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month PA, Yea? 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

DHMH 17 Rev 1/2001

Figistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

08-03580 William Dasher Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hyoiene

Illiain Dasilei	1- For State Registrar Reg. No.	1632
Physician/ ledical Examine	1. Decedent's Name (First, Middle,Last) William Lamont Dasher, Jr. 2. Date of Death Month Day Year	
V	4a. Facility Name (if not institution, give street and number) Harbor Hospital 4b. City, Town, or Location of Death Baltimore	
Funeral Director	5. Social Security Number 214-48-0009 6. Sex 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 27. F 59 Yrs. F 5	
ow any	Md Baltimore City	de City Limits
th the Maryland 13a or 28a-f show utified at once.	10e Street and Number 10f. Zip Code 10g. Citizen of What Country?	
or items 23amust be noti	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indiar White, etc. White	ı, Black,
를 를 될 중	3 Widowed 4 Divorced in res, diversely or Dates: 15 Decoder's Level Occupation (Give kind of work done 16b Kind of Rusiness/Industry)	
21215-0036 uld be filed within 72 hour Mental Hygiene. marked other than "natu c event, the Medical Exan To Be Completed	9th Car Detailer Auto Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Postary Transport	
MD 21214 d 2 should be fil lith and Mental F n 17 is marked aumatic event, 1		
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur injury or other traumatic event, the Medical Exami	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Holly Cross Cemetery 5/16/08 Baltimore. Md	
Baltimore, permit. Pages I an Department of He. Important: If ite injury or other tr	21 Signature of Funeral Service Licensee 22. Name and Address of Facility Conce Funeral Service P. A 4001 Ritchie Hewy. Balto. Md. 21225	Α.
Physician /Medical Examiner	23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease	imate Interval en Onset and Death
(July	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
ed nsit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
760, Totale be executed Sphysician and the burial - transit	0.	
Box 6876(ne death certificate the attending phy- had for use as the bhy- hysician/Me	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of 5 Other (Specify)	Year
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cords aw requestas been 2 should	24a. Was an autopsy find autopsy performed? death? 1 Yes 2 ✔ No 1 Yes	
rital sician: is certif lirector,	25. Was case referred to medical examiner? Hospital: 4 Inpution: 2 FR/Outputient 3 DOA Other, Nursing Home 5 Residence 6 Other;	
ion of Vital Rec leading Physician: The leading Appricant The lor. After this certificate the funeral director, page ation: To Be Constinant To Be Constinant To Be Constinant To Be Constinant To Be Constinant To Be Cons	27 Manuar of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred	
Division os spital or Attending nours after death, neral Director: After filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route or Town, State)	Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		s)
F 3 F 8 J	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, O.C.M.E. May 12, 2008	Year)
	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	·
State Registra	MID Y Z II ZIIIX I NYA o NY NYA MY M	

DHMH 17 Rev 1/2001 OCME 2006 08-03688

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 | 6327

Richard Winston		State of	Maryland / Depa	irtment of <i>tificate of</i>	Health an Death	ia Menta	ai mygieti		L L	100 1002
	R	egistrar . Decedent's Name (First, Middle,Last)		tilicate or	Death		2. Date	of Death		3. Time of Death
Physicia Medical Exami		Richard Winst	on Fried					n Da 14, 2008		1542 hrs
Z		a. Facility Name (if not institution, give st			4b. City, Town, o	r Location of	Death		4c. County of Dea Baltimore Co	
	Н.	5436 Princess Drive			Rosedale	ar If Under	24Hm 8 Da	te of Birth (N		Birthplace (State or
Funeral		6. Sex	7. Age (In yrs. I	5.1	If Under 1 Ye Months Da			/11/1	956 For	eign Country MD
Director			2 F	Yrs			<u> </u>			
any	-	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Locat						10d. Inside City Limits
AL .		MD Baltimo	re		Balt	imore	9			1 Yes 2 No
arylan arylan at onc	Director	10e. Street and Number			10f. Zip Code			10g.	Citizen of What Co	1
the M	ä	5436 Princess D	rive			2123				SA lerican Indian, Black,
12135 death with the Maryland or items 23a or 28a-f show must be notified at once.	eral	T. Horitan Clare	2. Was Decedent Ever in U Armed Forces?	J.S. 13. Wa	as Decedent of F es, specify Cub	lispanic Orig an, Mexican,	in? (Specify Y Puerto Rican,	es or No- etc.)	White, etc	
death or item	Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced If	Yes 2 X No	1	Yes 2XX	lo specify:			Specify:	White
s after aral", miner	þ	3 Widowed 4 Divorced If a Divorced II a Divo		16a Decede	nt's Usual Occur	ation (Give I	kind of work do	ne 16	b. Kind of Busines	ss/Industry
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15-0036 The within 7. Hygiene. d other than the Medical	S	17. Father's Name (First, Middle, Last)				Ric		Jnkno		
21215-0036 build be filted within 72 hours after Montal Hygene. r marked other than "natural", ie event, the Medical Examinez.	Be C	Unknown 19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailir	ng Address (St	reet and Nun	nber or Rural R	oute Numbe	er, City or Town, S	tate, Zip Code)
MD 2 nd 2 shoul alth and M m 27 is rr	To	Barbara Fried/	Wife						adelphi	a PA 19114
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other transmaite event, the Oxfordical Examiner must be notified at once	-	20a. Method of Disposition	20b		osition (Name of other place)		Date		Baltimo	
nor ages lages lant of lant. If		1 Burial 2 XCremation 3 4 Opnation 5 Other Specify:	Removal from State Ba	_	other place) Crema					
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. It re of the ral Service License	111		Name and Addr					Balto. MD ex 21221
≣. ₹ 6 % 00	_	23a. Part I. Enter the disease, or complic	M/A	th. Do not enter	onnell	y Fun	cardiac or resp	iratory arres	of Esse	Approximate Interval
Physician Medica		failure. List only one cause on ead	vine.							Between Onset and Death
amine		Immediate Cause (Final disease or condition resulting in death)	Typertensive athue to (or as a consequence	neroscler e of):	otic card	iovascu	lar dise	a se		
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	ner	if any, leading to immediate cause. Enter Underlying Cause	ue to (or as a consequence	of):						
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(0, e be executed ysician and hurial - transi	edical	X UNPENDED	AMENDED 23a, 27, perME, g8	80 6/20/	08 TT				23d. Date of de	livery
Box 68760 te death certificate by the attending physicate of the physicate by	Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pr		Fetal death	3 Ector	oic pregnancy		Month	Day Year
Box 6876: death certificate the attending phy	iciar	past 12 months?	4 Pregnant at time of	death 5	Other (Specify)					
Boy e death	Physician/M	1 Yes 2 No 9 Unknown Part II. Other significant conditions	g Unknown	at reculting in th	e underlying cau	ise given in I	Part I.	23e. Did tot	acco use contribu	ite to the cause of death?
ords, P.O. B v requires that the d	S S	Part II. Other significant conditions	contributing to death but no	of resolung in an	e underlying out	J		1 Yes	2 No 3	Probably 4 V Unknown
S, F puires	ed le	l						24a. Was a		ere autopsy findings available or to completion of cause of
ord aw rec	2 snor							autops perfor 1 Yes	med? dea	ath? Yes 2 No
Division of Vital Records, fall relaw require its after death.	Completed				26.5	Place of Deal	h (Check only			
ital ician: s certi	Be Ecto	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2	ER/Outpati	ent 3 DOA	Other ₄	Nursing Ho	ome 5	Residence 6	Other: Scene
of V g Phys fer thi	funeral du	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time		Injury at Wo		. Describe h	low injury occurred	i
on con cending	the fur	1 Natural 5 Pending 2 Accident Investigation				Yes 2				- Dural Pouts Number City
VISI or Atti fter de Directe	in by i	2 Accident Investigation 3 Suicide 6 Could not	28e. Place of Injury - A	At home, farm, s	treet, factory, of	fice building,	etc. 28f	. Location (S or Town, S		or Rural Route Number, City
Di pital cours a ours a	Certification:	4 Homicide determined	1-1 27				place and due	to the caus	e(s) and manner a	as stated.
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and the control of the control			an: To the best of my know	vledge, death or on and/or invest	curred at the tin tigation, in my of	ne, date and pinion, death	occurred at the	e time, date	and place, and du	e to the cause(s)
To th	Completel	29b. Signature and title of certifier	and manner stated.			icense numb			29d. Date signed	d (Month, Day, Year)
	1	has has	, not			C.M.E.			May 15, 200	08
		30. Name and address of person who	completed cause of death (Item 23a)						
10 Cent		Ling Li, MD Assistant M	edical Examiner 1	111 Penn Si	treet, Baltime	ore, MD 2	1201			
1 1	Stat	31. Date filed (Month, Day, Year) MAY 2 0 2008	32. Registrar's Si	pature	det.					

			For State Registrar	State of Marylan		artment of H <i>tificate of D</i>		d Mental Hy	giene Reg. No. 200	8 16328
	Physici		1. Decedent's Name (First, Middle, Last) JUNIUS			FLOV	7)	2. Date of De Month	Day Ye	ar 1955 M
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of De	eath /	4c. County of D	·
	<i>)</i>	23	The Johns Hopkins Ho 5. Social Security Number 6.		last hirthday)	Baltimore If Under 1 Year	City If Under 24 F	rs. 8. Date of Bi	rth 9.	Birthplace (State or Foreign Country)
	Funeral Director			OM 2□F 34		Months Days	Hours M	in. (Month, Da MAR •		MD
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	death with the Marylan ms 23a or 28a-f show must be notified at	ctor	MD	BA	LTIMO	RE				1 X Yes 2 ☐ No
	or 28	Director	10e. Street and Number	, 32.		10f. Zip-Code			10g. Citizen of What	Country?
	eath w	Funeral	810 ABBOTT CT.	12. Was Decedent Ever in U.	e 112.1	21205	enanic Origin?	(Specify Ves or No	USA	merican Indian,
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar	Specify:	erto Rican, etc.)	Black, W Specify: E	hite, etc.
21	⊂ ³_8	Completed	15. Decedent's Edu (Specify only highest gradi Elementary/Secondary (0-12)		(Give life, L	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of v	working	16b. Kind of Busine	
d 21	filed within Hygiene. other than "		12TH 17. Father's Name (First, Middle, Last)		FC	OD SERV		Name (First, Middle	FAST F e, Maiden Surname)	<u> </u>
Maryland	should be and Mental s marked o	To Be	DANNY FLOYD				CHAN	IDRA DOD	DD	
Man	12 sho and I is ma rauma		19a. Informant's Name/Relationship (Ty)	·					ber, City or Town, State	
	1 and 2 Health tem 27 other tra		CHANDRA WALKER/ 20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of	i	BALTIM Date	IORE, MD 20c Location - City 5500 O D	21205 or Town State
OE I	Pa Fire Fi		1 ☐ Bunal 2 X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		natory`or other place VIEW		16/08	BALTIMOR	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other troone.		21. Signature of Funeral Service License	enth:		2007-09	EASTE	ERN AVE.	CHAVIS, J	
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only on	ications that caused the death le cause on each line.	n. Do not ent	er the mode of dying	g, such as card	diac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence)	nunoc	deficience	1 VIRU	15		6 Years
-	Examiner		.	Awni Rec	e Iv	nmunod	efice	inul S	Syndrom	e GYEARS
-	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	uence of):					
_	ifficate be executed g physician and as the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence)	uence of):					
8760,	ate be raysiciar	edical	C.	d						
9	certifica ding pl		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy				23d. Date of	delivery
P.O. Box	The law requires that the death certifi te has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Feta 4 Pregnant at time of de 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
	w requires that been signed b should be det	þ	Part II. Other significent conditions cor	ntributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.	23e. Did		e to the cause of death? Probably 4 Unknown
Records,	The law rer e has bee age 2 sho	Completed						24a. Was auto perfo 1 Yes	psy prior deatl	e autopsy findings available to completion of cause of h? Yes 2 \sumbox No
of Vital	stcian: Th certificate irector, pa	Be	25. Was case referred to medical examiner?	Hospital:	/	Other	r.	eath (Check only o		
	Physician: this certificatral director,	은	1 ☐ Yes 2 ☑ No ☐ 27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	28c. Injury	at Nursing	Home 5 Resi	dence 6 Other (S how injury occurred	pecify)
ion	• Attending Fer death. • ector: After by the funer	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work	? ′es 2 ⊡ No			
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location City or Tox		r Rural Route Number,
	To the Hospital o within 24 hours aft To the Funeral DI completely filled in	Medical		sician: To the best of my knowner: On the basis of examinat and manner stated.						
	To the within 2	Me	29b. Signature and title of certifier	lk.		29c. License		,	29d. Date signed (Mo	onth, Day, Year)
			Mistre	1 Danes	-	Dol	06/01	14	5/13	12008
			30. Name and address of person who co	100	n 23a) (Type, 55 e.t	Print)	60	0 North Wo	olfe St, Baltir	nore, MD, 21287
	Sta	_	31. Date filed (Month, Day, Year)	32 Registrar's Signat		- P				
	Registr	:10	12 EV 0 0 0000	Mr. A	The same	162 0				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 2008 2:06 PM Mery /Medical 4a. Facility Name (If not institution, give stree Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 12 M 2□ F Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1. Yes 2 No by Funeral Director 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a USA Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Black 3 ☐ Widowed 4 ☐ Divorced Completed Is marked other than "natur raumatic event, the Wedical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Specialist lears 18. Mother's Name (First, Middle, Maiden Surname) Be 2 ene or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a tem 27 Is terrace Angelica AHTMUCIMO 21204 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State -20-08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician disease or condition resulting in death) YELLICE /Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death P.O. I 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 No 1 □Yes 20No 1 🗌 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 20 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 11 Natural 5 ☐ Pending investigation death. 1 ☐Yes 2 ☐ No within 24 hours after death To the Funeral Director: the 1 2 Accident 6 ☐ Could not be 3 T Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

MAY 2 0 2008

KNOUN

32. Registrar's Signature

			1 - State of Maryland / Department of Health and N per fh, g879,05/20/08dhb of Death	lental Hy	giene 2	008	16330
r	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic	_	MOSES GUESS, JR.	May		r098	1025 AM
3	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	•	4c. Cour	ity of Deatl	n
No to co	Funeral		UNTON MEM HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bir	th	9. Birtl	hplace (State or Foreign
ŀ.	Director		212-60-9436 X M 2 F 54 Yrs. Months Days Hours Min.	(Month, Da 11–26		Col	54 MD
	and W		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryle f sho	ior	MD BALTIMORE				1 TarYes 2 □ No
	r 28a- notif	Director	10e. Street and Number 10f. Zip Code		10g. Citizen o	of What Co	untry?
	th with	al D	4802 BEAUFORT AVENUE 21215		USA	1	
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.))- 14. R B	ace - Amei lack, White	rican Indian, e, etc.
21215-0036	ours aff ral", or Exami		1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2		Spec	city: BL	ACK
2-0	72 hc 'natur dical	etec	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	ing	16b. Kind of	Business/I	Industry
121	within iene. than "	Completed by	Elementary/Secondary (0-12) College (1-4or 5+) LABORER		CONS	TRUCT	TON
d 2	Hygi other ent, tl	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle			LION
ylan	should be ind Mental marked c	To B	MOSES GUESS, SR. NAN	CY GUE	SS		
Maryland	nd 2 sho alth and 27 Is ma ir trauma		19a. Informant's Name/Relationship (Type. Print) MOSES GUESS, SR/FATHER 19b. Mailing Address (Street and Number or Run.		-		, ,
	tem 27		20a. Method of Disposition 20b. Place of Disposition (Name of	UE BA Date	20c. Location		
E O	Pages nent of I ant: If ite any or of		1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) CEDAR HILL 5/20/	'08	BALTO.	, MD	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility	ES A. I		_	IS F.H., INC
<u> </u>	8 3 1 6 8		James a. Wyoten 1701 LAURENS ST.,				
			23a. Part̃1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory a	arrest,		Approximate Interval Between Onset and Death
9	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)				
١	Examiner		Due to (or as a consequence of):				Gays Unknown
1	-	Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				Chenswy
/	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events c.				
8760,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
	icate t physic	dical	d	<u> </u>			
Box 6	death certific attending p	n/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy		23d. [Date of deli	iverv
-	death e atte	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Helpanara 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		4	Month	Day Year
0	at the	Phys	9 DONATIOWIT	I ag . Più			
Records,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	<u>ک</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use co Yes 2 No		the cause of death? obably 4 Dinknown
000	aw rec	Completed		24a. Was		b. Were au	topsy findings available
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or.	Physi this o	6	1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Ho 27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury at				cify)
O	ding h. After funer	tion	27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No	zou. Describe	how injury occ	unea	
Division or	or Attending Physician; The after death. Director: After this certificate he in by the funeral director, page	ifica	2 Posicida 6 Could not be			mber or Ru	ıral Route Number,
Ö	ital or urs afte ral Dir lled in	Certification:			wn, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the red at the time	cause(s) and , date and plac	manner as e, and due	stated. to the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier 29c. License number		29d. Date sig	ned (Monti	h, Day, Year)
			Model Jaron, D.O. AT 2438946	- H2	May	15,	2008
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew Baran, D.O. Union Memorial Hosp.	test :	MD		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		1 7		
	Registr	ar	MAY 2 0 2008 / Server 2. Server				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 8 **Physician** Month Year GERALDINE GREEN 13:07 PM MAY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Johns Hopkins Bayview Hospital If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F 220-22-2980 Mary Director land Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 1 No Salto undulla 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with "natural", or items 23a or dical Examiner must be r U.S.A. by Funeral 21222 2 should be filed within 72 hours after death and Mental Hygiene. Is marked other than "natural", or items 23: Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ₩idowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 mema 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be timent of Health and Menta illiam LABE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rucal Route Number, City or Town, State, Zip Code) Barbara 118 Ann Wal or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) nlace) permit. Page Department o Important: If any Injury or 23 22. Name 21. Signature of Funeral Service Licensee Freneral Service 1701 McCullon St. Balto · hd. 23a. Part1. Enter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on expline. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ventricular Tachycardia 5 minutes /Medical Due to (or as a consequence of): Examiner years End Stage Renal Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as for use IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Vear 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) P.0. signed by the a Id be detached f 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No s certificate has t irector, page 2 s 24a. Was an autopsy performed? Yes 2 No 1□ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 No 1 Minpatient 은 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) within 24 hours arter community to the Funeral Director; Aft 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 ony, Medical Doctor May 18,2008

State Registrar Janice

Leung, Johns Hopkins Bayurew Hospital, 4940 Eastern Avenue, Battimore, Maryland 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 0 2008

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician Catherine Howe Grant 17 1:19 PM May 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Hospice Casey House Montgomery Rockville If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Funeral 1 □ M 2 X F 206-44-0848 Director Sept. 30, 1952 Pennsylvania 55 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show Examiner must be notified 1 ☐ Yes 2 ☐ No Directo Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 12809 Huntsman Way 20854 United States items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Yes 27 No 1 ☐ Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White Specify. by 3 Widowed 4 Divorced Year or Dates: "natural" Completed f Health and Mental Hygiene. Item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Adjunct Professor of Speech Montgomery College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Howe Catherine DeFalco 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David A. Grant / Husband 12809 Huntsman Way, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other plac Parklawn Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 21, 2008 4 Donation 5 DOther (Specify) Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville Inc. 300 West Montgomery Avenue, Rockville, Maryland Inc. M01360 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician disease or condition resulting in death) Colon Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛂 No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has trector, page 2 s autopsy performed? Yes 24 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}X$ JOther (Specify) Hospice IRU1 ☐ Yes 2 ☒ No P this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 X Natural 2 ☐ Accident ours after death.

neral Director: A
filled in by the for 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signate d title of certifier 29d. Date signed (Month, Day, Year) D0064615 May 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Anne Wroblewski 6001 Muncaster Mill Road, Rockville, Maryland 20855 31. Date filed (Month, Day, 32. Registrar's Signatur State 0 2008 Registrar

Shabbir Hussi	ion	State 1- For State Registrar	e of Maryland / Dep Co	oartment o e <i>rtificate o</i>		d Mental Hy	-	g. No. 2	008 !6333
Physi		1. Decedent's Name (First, Middle,La		ir Huss	ion		Date of Death Month	h Day Year	3. Time of Death 0339 hrs
Medical Exa	mine	4a. Facility Name (if not institution, g		oli nuss	4b. City, Town, or I	ocation of Death	May 19, 20	108 4c. County of	
		St. Agens Hospital	ive street and number)		Baltimore	F			
Funera Directo				s. last birthday)	If Under 1 Year Months Days		1 13)	Birthplace (State or Foreign
		085-74-7467 15 Usual Residence of Decedent	x M 2 F 43	Y	rs.		04/10	/ 1965	Country) Pakistan
any	1	10a. State 10b. County	10c. Ci	ity, Town or Loca	ation				10d. Inside City Limits
land f show	al la	MD Baltin	more Ba	altimor	:e				1 Yes 2 X No
3¢.	irer!	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	it Country?
213¢		2656 Virginia 11. Marital Status	Avenue 12. Was Decedent Ever in	11S 13 W	21227	nanic Origin? (Spe	ocify Yes or No-	USA	American Indian, Black,
, MD 21215-0036 (22) AD 21215-0036 (24) AD 21215-0036 (25) And 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygene. (24) And 12 is marked other than "natural", or items 23a or 28a-f she	Funeral Director	1 Never Married 2 Marrie		If	Yes, specify Cuban,	Mexican, Puerto F	Rican, etc.)	White,	
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re, rand and Healt		20a. Method of Disposition	20t X Removal from State	h Place of Disno	sition (Name of cerr	netery	Date	20c Location - C	City or Town, State
more Pages I nent of F		4 Donation 5 Other Specif	fy: Removal from State	lussair	other place) Tamily	Cem 05	/21/08	Laho	r, Pakistan
Baltimore, permit. Pages I at Department of He Important: If ite	ulum	21 Security of Funeral Service Lice	11- ()	l N	Name and Address	of Facility neral Ho	me 430	00 Waba	sh Ave.
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/Medica	al	failure. List only one cause on a	each line. a. Atherosclerotic	c cardiov	ascular dise	ease			Between Onset and Death
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	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	e of):					
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cuted hind			d.						
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68760, certificate b	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre	egnancy	etal death 3	Ectopic pregnan		23d. Date of d Month	
	Physician/N	past 12 months?	4 Pregnant at time of	dooth =	other (Specify)				
). Box of the death of the death of by the atten	Phys	Part II. Other significant conditions	9 Unknown	t resulting in the	underlying cause gi	ven in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
P.C es that igned	<u>a</u>		3		,g				Probably 4 🗸 Unknown
of Vital Records, ng Physician: The law requir ther this certificate has been so	Completed						24a. Was a		ere autopsy findings available ior to completion of cause of
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f Vii Physic er this	ူ	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2	✓ ER/Outpatier 28b. Time of				Residence 6	Other:
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Division tal or Attendirs after death.	ig	2 Accident Investiga 3 Suicide 6 Could no	28e Place of Injury - At	home, farm, str	eet, factory, office bu	uilding, etc. 2			r or Rural Route Number, City
ie Spi	j	4 Homicide determine				Į.	or Town, St	ate)	
D To the Hospital within 24 hours To the Funeral Completely filled		29a Certifier 1 Certifying Physic one) 2 Medical Examine	ician: To the best of my knowle er:On the basis of examination	edge, death occi and/or investig	irred at the time, dat	te and place, and dideath occurred at	fue to the cause the time, date a	e(s) and manner a and place, and due	is stated. e to the cause(s)
و المرابع	Medical	29% \$ignature and title of certifier	and manner stated		29c. License				d (Month, Day, Year)
		(al alen	40		O.C.M	1.E.		May 19, 200	18
		30. Name and address of person who							
			stant Medical Examiner		n Street, Baltim	ore, MD 2120	1		
Regi	State stra	## /\ \/ 63 /\	2008 32. Registrar's Signa		rade				

DHMH 17 Rev 1/2001 OCME 2006

OCME

Amend Item: 27 State of Maryland / Department Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 9:00AM 13, May 2008 Charles Ε. Houck, III /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3524 Lawndale Road, East Reisterstown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours **№** M 2□F Months Yrs 72 May 16, MD Director 215-32-4092 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2√☐ No Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 3524 Lawndale Road, East 21136 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No If Yes, Give 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If 7es, Give Year or Dates: 1953-57 Specify Specify ₹ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Baltimore County Fire Firefighter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Charles E. Houck, Jr. Wilma L. Mann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3524 Lawndale Road, East, Reisterstown, MD 21136 Wife Nancy W. Houck 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowbranch May 16.08 Westminster, Md. 21. Signature of Funeral Service Licepe 22. Name and Address of Facility 11824 Reisterstown Road 120 Eline Funeral Home Reisterstown, MD 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sch line. Approximate nterval Betweer Immediate Cause (Final sease or condition resulting in death) mon **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death/but not resulting in the underlying cause given in Part I. Completed by 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 4b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy page 2 certificate 1☐ Yes 2 or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl Certification: To Be Other: 4 \sum Nursing Home 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) After this Mayner / 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred eath Injury 5 ☐ Pending investigation tural 1 ☐ Yes 2 ☐ No death. after death filled in by the 6 Could not be Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person YUSU Registrar's Signature 3 . Date filed Month, DI State 2-0-2008 Registrar

1241

Darron Hunt State of Maryland / Department of Health and Mental Hygiene 2008 16335 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day May 15, 2008 1457 hrs Medical Examiner Hunt Darron 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Johns Hopkins Hospital Raltimore N/A If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours oreign Directo 219-78-5777 1 25 1967 Country) MD 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 10b. County N/A 1 X Yes 2 No MD Baltimore or 28a-f show hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 2818 Ashland Avenue 21205 USA Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes Black 3 Widowed 4 Divorced Yes 2X X No specify: Specify: 2 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72.1 the Medical Itimore, MD 21215-0036 Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene.
ant: If item 27 is marked other than N/A Nutrition Dept. JHH 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u>Johnnie</u> Hunt Sarah Ingram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ Sarah Hunt-mother 2818 Ashland Avenue Baltimore, 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 5/23/08 King Memorial Pk. Randallstown MD ment tant: 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 1101 E. North 0 ۵ Baltimore, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Lung disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical the attending physician and for use as the burial -X UNPENDED AMENDED, 23a, PII, 27, perME, g881, 7/1/08 TT Box 68760. IE EEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 V Unknown Cocaine and narcotic (morphine) use Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has performed? death? 2 No certificate ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 After this 1 V Yes No 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Director: 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) within 24 hours a To the Funeral I determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 16, 2008 - MD M 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month Pay, 2010) egistrar's Signat State 2008 ENG. Registra

DHMH 17 Rev 1/2001 OCMF 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** 5:00 a M May 18, Raymond C. Hall /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore College Manor Lutherville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours 1**∑** M 2 □ F 91 210-03-1376 Director January24,1917 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Baltimore Baltimore 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 28 Clipper Road 21221 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by XIXWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Draftsman Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Hall Mary Horseman ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Douglas Hall/ Son 2749 Greene Lane Baldwin, MD 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 4 ☐ Donat ∠ □ Cremation 3 □ Removal from State Gardens of Faith 05/21/08 Rossville, MD 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Avenue Baltimore, Connelly Funeral Home of Essex MD.21221 22. Name and Address of Facility meral Service Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on explaine. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed^a 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 1 Inpatient 2 ER/Outpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie State Registrar

08-03537	
Voltaire Harris	

oltaire Ha	arris		State of Maryland / Department of He 1- For State	anth	2008 1633
	nysicia Evami	an/	1. Decedent's Name (First, Middle,Last) VOLTAIRE A. HARRIS	2. Date of Dea Month	Day Year
Medical L		liei		May 8, 20	4c. County of Death
			Maryland General Hospital Ba	altimore	
	neral ector		226-78-0319 1XM 2 F 54 Yrs.	lonths Days Hours Min.	rth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) NC
	any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Pu	≱ .	٦	MD N/A BALTIMOR	E	1 X Yes 2 No
Ø Maryla	28a-f	ect			10g. Citizen of What Country?
th the J	23a or notifie	ä	101 ST CHARLES ROAD	21225	USA
r death wi	Department of Health and Mental Hygjene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, t <u>he Medical Examiner must be notified at once.</u>	Funeral Director	1 Never Married 2 Married Armed Forces? If Yes, s	cedent of Hispanic Origin? (Specify Yes or Nepecify Cuban, Mexican, Puerto Rican, etc.) 2X No specify:	o- 14. Race - American Indian, Black, White, etc. Specify: BLACK
urs aft	tural"	b b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's U	sual Occupation (Give kind of work done	16b. Kind of Business/Industry
6	an "na	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	f working life. DO NOT use retired)	
003 within	her th	E E	1.2 CON	NTRACTOR 18. Mother's Name (First, Middle,	SELF EMPLOYED
215-0036 be filed within 7	ked of	Be C	ELLIS EDWARD HARRIS		ERSON
21; nould b	is mar	P	19a. Informant's Name/Relationship (Type, Print)	dress (Street and Number or Rural Route Nu	
, MD	ealth ar em 27 rauma		PEGGY A. HARRIS - WIFE 101 ST	CHARLES RD, BAL	LIMORE, MD 21225
Baltimore,	ment of H tant: If it or other t		1 X Burial 2 Cremation 3 Removal from State crematory or other p 4 Donation 5 Other Specify: KING MEMOR	RIAL PARK 5/14/08	RANDALLSTOWN, MD
Ball permit	Importingury		21. Supature of Funeral Service License 22. Name	and Address of Facility HOWELL F	UNERAL HOME AVE, BALTIMORE, MD
Phys	ician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m		rest, shock, or heart Approximate Interval
*	dical niner	1	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive atheroscleroti	c cardiovascular disease	Between Onset and Death
Adi			or condition resulting in death) Due to (or as a consequence of):		
		je l	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause		
20	ısit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	··	
execut	hysician and le burial - transit	ical	d. V UNPENDED AMENUSEDPTT 27 perMF a879 5/2	2/00 777	
60 , ate be	physici he buri	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	3/08 TT	23d. Date of delivery
Box 687	e attending phy for use as the	ian/	23b. Was decedent pregnant in the past 12 months?		Month Day Year
Box death	the atte	nysic	1 Yes 2 No 9 Unknown	(Specify)	
that the	ned by the detached		Part II. Other significant conditions contributing to death but not resulting in the under		tobacco use contribute to the cause of death? es 2 No 3 Probably 4 ✔ Unknown
IS, F	en sign uld be	Completed by	Diabetes mellitus; cocaine use	1Ye	
COFC	has be	nple		auto	ppsy prior to completion of cause of death?
of Vital Records, P.O.	certificate ector, page		25. Was case referred to medical	1 ✓ Yes 26.Place of Death (Check only one)	2 No 1 Yes 2 No
Vita	his cer direct	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	1 Othor:	Residence 6 Other:
of ing Ph	After t		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		how injury occurred
Division	ector:	catic	2 Accident Investigation	1 Yes 2 No	(Cheek and Number or Dural Devile Number City
Divi	ral Dir	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town,	(Street and Number or Rural Route Number, City State)
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 ho To the Fune completely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a cone) 2 Medical Examiner: On the basis of examination and/or investigation,		
Tot	To the	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	1		hi hi mo	O.C.M.E.	May 9, 2008
1			30. Name and a dress of person who completed cause of death (Item 23a)		
N	-		Ling Li, MD Assistant Medical Examiner 111 Penn Street, E	altimore, MD 21201	
	St Regist	ate trar		,	
Driiviri 17			ORIGINAL	200	ie.

			State of Maryland / Dep 1- State Amend Items 20b, c per fh, g879	ermicate or De ath	Reg.	No.2000 10000
# # T	Physic /Medi		1. Decedent's Name (First, Middle, Last) William Holden		2. Date of Death 05-16-2	3. Time of Death 0; 15 a M
)	Exami	ner	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Clinton If Under 1 Year If Under 24 Hrs.		4c. County of Death
	Funeral Director		215-98-9106	Months Days Hours Min.	8. Date of Birth 03-26-19	9. Birthplace (State or Foreign Country) VA
:	ne Maryiar 8a-f show otified at	Director	10a. State 10b. County 10c. City, Town or L Camp Sp.			10d. Inside City Limits 1 ⊠Yes 2 □ No
:	eath with ti		10e. Street and Number 6223 Maxwell Dr. Apt#4	10f. Zip Code 20746	U.	Citizen of What Country?
036	ours after d ral", or iten Examiner	by Funeral	11. Marital Status 1	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	city Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify Black
21215-0036	permit. Fages I and 2 should be filed within 72 hours after death with the Maryland perpetrient of Health and Mental Hygiene. Important: I filem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired) CkLayer	ng	Kind of Business/Industry
land 2	uld be filled Aental Hygi rked other tic event, ti	To Be Co	17. Father's Name (First, Middle, Last) William Holden		(First, Middle, Maid Brooks	len Surname)
Baltimore, Maryland	is I and 2 sho of Health and N Item 27 is ma other trauma		Phyllis Holden-Mother 622	ling Address (Street and Number or Rura 3 Maxwell Dr. Ap	l Route Number, Cit	y or Town, State, Zip Code) 20746 p Springs, MD
Itimore	rtment of H rtant: If Ite njury or ot		4 □ Donation 5 □ Other (Specify) Heritage	e Cemetery 05/23	/2008 Wall	Location - City or Town, State
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He law	has b	Completed	Musilnerory 25. Was case referred to medical		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
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		1 - For State Registrar	State of Ma	ryland	•	rtment of H tificate of L		nd Me	-	ene g. No. 2	008	6	339
Physi /Med		Decedent's Name (First, Middle, RAY	Last)			HERLING			Date of Death Month MAY 1	5 Z	2008	3. Time of D	
Exam		4a. Facility Name (If not institution, 6317 PARK HEIG 5. Social Security Number	HTS AVENUE,	#615	hirthday)	4b. City, Town, or BALTIM	ORE		. Date of Birth		nty of Death	N/A	Foreian
Funera Directo		219-03-0511 Usual Residence of Decedent	X□ M 2□ F	88	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day,) 05/4/1	920		place (State or ntry) MD	
the Marylar 28a-f show	ector	MD 10b. County N 10c. Street and Number	A	10c. City, T	TIMOR				100	r Citizen	of What Cour	1 X Yes 2	
ITE, INIAL VICILIA ZIZIO-UOSO 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar mast be mutitled at	Funeral Director	6317 PARK HEIGH	TS AVE., #61 12. Was Decedent E Armed Forces?		13. V	21215 Vas Decedent of His Yes, specify Cuba		n? (Specif		USA 14. F		can Indian,	
3-UUSO 72 hours after natural", or ite	þ	1 ☐ Never Married 2 ☒ Marrie 3 ☐ Widowed 4 ☐ Divorced 15. Decedent	d 1 ⊠Yes 2 □ N If Yes, Give Year or Dates:		1	Yes 2 No	Specify:	T de lo riic		Spe		WHITE	
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re, Ivial s 1 and 2 st f Health an item 27 Is r other traur		19a. Informant's Name/Relationsh BARBARA HERLIN 20a. Method of Disposition		20b. Plac	6317	g Address (Street a	IGHTS	AVE.	, #615	21215	BALTI on - City or To	MORE, N	MD
t. Page rtment or rtant; If	once.	1 Maurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L.	ecify)	ARL	INGTO	Name and Address	AMUNO	-				INC.	
1 50 E 6	o	23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final	nly one cause on each lin	e.	Do not ente		g, such as ca				LLE. M	Approximate Interval Betw Onset and Do	veen
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
w requires that the death certifications is signed by the attending is should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗀 Fetal de	ath 3 🗆	Ectopic pregnancy	/				Date of deliv Month	,	ear
Olds, requires that een signed to	\$	Part II. Other significant condition	es contributing to death bu		-	derlying cause give	en in Part I.			acco use c		the cause of de	
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investige 3 Suicide 6 Could n 4 Homicide determin	of be	ry - At home . (Specify)	, farm, stre		Yes 2□No		f. Location <i>(Stre City</i> or Town,		umber or Run	al Route Numb	per,
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To t with To th	M		Prehand C Be				20604			d. Date sig	gned (Month,	Day, Year)	
		30. Name and address of person w	Lichard A. Bergo A	9,5-164	150; 10	755 Folls Ral; 1	-uTherville	_, hol Z	1093				
S Reais	tate strar	31. Date filed (Month Par Year)	0 2008 32. Registra	r's Signature	× L	back							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 2008 WILLIAM ALLEN JAMES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pital Year If Under 24 Hrs. Days Hours Min. altimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Funeral Days Months 1**∑** M 2□ F Director JUNE 25, 1934 219-76-9280 73 NC Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ortant: If Item 27 Is marked other than "naturar", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □No Director MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral death v 1606 E. FAIRMOUNT AVE. 21231 USA 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 █No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 BLACK 1 ☐ Yes 2 🔀 No Specify. Specific ģ 3 ☐ Widowed 4 🖾 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HT8 LABORER FACTORY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Department of Health and Mental MARTIN_JAMES ABBIE WOODLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA REYNOLDS 4760 MELBOURNE RD., BALTIMORE, MD 21229 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5712 O DONNELL ST. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 05/13/2008 BALTIMORE, MD 21224 21. Signature of Funéral Service Licens 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Pan 1. Enter the aveas shock, or hear wilure. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest are. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 1+heroscierotic /Medical Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-trar Due to (or as a consequence of) attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by the should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Yes 2 □ No 1 🔲 Inpatient 2 € ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Division or Vital Records, P.O. Box 68760, al or Attending Physician: after death. I Director: After this certifica To the Hospital of within 24 hours af To the Funeral D

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Johent

6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier what M.D.

of death (Item 23a) (Type, Print)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 17 2008 **Physician** May 12:50M C. Jackson, Jr. William /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT 4 1947 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 60 212-50-0121 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f shov 1 ☐ Yes 2 🏋 No MD Silver Spring **Funeral Director** Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20901 10723 Meadowhill Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 7 Is marked other than "natural", or item traumatic event, the Medical Examinan Black White etc. Pages 1 and 2 should be filed within 72 hours after on the setter of Health and Mental Hygiene. Armed Poices: 1 XYes 2 No If Yes, Give Year or Dates: Vietnam 1 Never Married 2 Married 1 ☐ Yes 2 👿 No Specify þ Specify: 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Office of College (1-4or 5+) Elementary/Secondary (0-12) Attornev Manager Personnel Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Heferstand С. Dorothy Jackson, Sr. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Antonette Marzotto - wife 10723 Meadowhill Road, Silver Spring, MD 20901 Health a permit. Pages 1 and 2 Department of Health Important: If Item 27 I any injury or other tra once. 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date Metro Crematory, Inc. 5/19/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H 22. Cremation Society of Maryland, Inc. Williams 14u 299 Frederick Road, Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Myelodysplasia Syndrome disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of): physician a Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 ☐ Unknown 9 Unknown signed by the best of the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown certificate has been sirector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

the Hospital or Attending Physician: The law requires that the death certificate be execution to thours after death.

the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760, LIAN ACKSON within 24 hours a

To the Funeral [

death with the Maryland

Baltimore, Maryland 21215-0036

12/50

40+1

State Registrar

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Road, Bethesda, MD Suburban Hospital,

31. Date filed (Month, Day, Year) MAY 2 32. Registrar's Signature

2008

and manner stated.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Ple 1 - State Registrar	ease Type or Pri State of Ma		d / Depa	idelible Ink artment of H tificate of D	ealth and	Mental Hy		2008	16342
Physicia /Medic		1. Decedent's Name (First, Middle David 4a. Facility Name (If not institution			John	SOA 4b. City, Town, or	Location of Death	2. Date of De	Pay	Year 2008	3. Time of Death
Examine Funeral		The Johns Hopkins 5. Social Security Number	s Hospital		st birthday)	Baltimore If Under 1 Year Months Days		. 8 Date of Bir	th	N/A 9. Birthp	place (State or Foreign
Director		083-26-8222 Usual Residence of Decedent 10a. State 10b. County		72	Yrs. Town or Lo			AUG 5	1935		Od. Inside City Limits
Jeath with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number	Arundel	Pa	sadena	10f. Zip-Code 21122	2		10g. Citizer	of What Coun	1 ☐ Yes 2X No try?
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	è	58 Milburn Ci. 11. Marital Status 1 Never Married 2 3 Marital Status 3 Widowed 4 Divorced	12. Was Decedent 8 Armed Forces? 1 □ Yes 2 🔀 1 If Yes Give			Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🗓 No		pecify Yes or No o Rican, etc.)		Race - Americ Black, White,	
within 72 hou ene. than "natura he Medical E	Completed		nt's Education est grade completed) College (1-4 or 5	i+)	(Give life. i	dent's Usual Occup kind of work done o DO NOT use retired ipment Su	during most of wo)	-		of Business/In	
Mental Hygie arked other itic event, th	To Be Co	17. Father's Name (First, Middle, Edward John	son	,			18. Mother's Na	me (First, Middle Rossite	er	·	
1 and 2 sho Health and I em 27 is ma	- 9	19a. Informant's Name/Relations Susan Johnson 20a. Method of Disposition		20b. Pl	58 M	ng Address (Street ilburn Ci position (Name of	rcle, Pa		MD :	own, State, Zip 21122 tion - City or To	
permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once.		1 Burial 2 X Cremation 4 Donation 5 Other (5 21. Signature of Funeral Service	Specify) Licensee H. Willia Wen H. Willia	Met ams	ro Cre	ematory or other place ematory, Name and Addres Cremation 299 Fred	Inc. 5/1 ss of Facility erick Ro	y of Man ad. Bali	ryland		MD 21228
Physician / Medical Examiner sician and e prival-transit	ical Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	only one cause on each lin	a conseque	ence of):	er the mode of dyin	ng, such as cardia	scures	arrest,		Approximate Interval Between Onset and Death
The law requires that the death certificate be the has been signed by the attending physicia page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1	2 🗌 Fetal	death 3	☐ Ectopic pregnanc	у		230	d. Date of deliv	ery Day Year
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da) igation Inot be 28a. Place of Inju	iry y Year)	ER/Outpatier 28b. Time o Injury me, farm, str	of 28c. Injur Worl	er: 4 \sum Nursing F	Home 5 - Resi	idence 6 [how injury o	occurred	y) al Route Number,
tospital or A tours after uneral Directly filled in by	cal Certif	(check only 2 Medica	ng Physician: To the best of Examiner: On the basis of	c. (Specify, of my know f examinati) vledge, deat	h occurred at the tir		City or To	wn, State)	nd manner as	stated.
To the H within 24 To the Fi complete	Medical	29b. Signature and title of certific	and manner st		210-	29c. License				signed (Month,	
12		30. Name and address of person	40 M.D.						olfe St,	Baltimo	re, MD, 21287
Sta Registr		31. Date filed (Month, Day, Year)	0 2008 32. Registra	ar's Signati	I A	parte					

		4	For State Registrar	State of Maryland		tment of h			ene 0 0	8 63	+3
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Johnnie	Jones	-			2. Date of Death	17 20	3. Time of 0	Death M
	Examin		4a. Facility Name (If not institution, give s	451456	ME	Cold	r Location of Death	9	4c. Coupty	of Death	
	Funeral Director		5. Social Security Number 6. Sex 578-46-8997 Usual Residence of Decedent	M 2□ F 7. Age (In yrs. le	Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, 04 03		Birthplace (State or Country) DC	Foreign
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	3a or 3	iDir	5466 Harpers Fai	rm Road		10f. Zip Code 21	.244	11	U.S		
	ome 2	Funerai		Was Decedent Ever in U.S Amed Forces?	5. 13. W		Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)		e - American Indian, ck, White, etc.	
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altimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	omoval from State	metery, crema	ition (Name of atory or other pla L Harmo		Date	20c. Location ·	City or Town, State	
Ħ.	그 문문을 .		4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service License	Mei	morial	Park Name and Addition Ch F/F	5/21	/08 L	andov	er, Md	
<u>~</u>	permi Depa impo eny ir		> Xernallal C.s	fuoNy	430	00 Waba	sh Ave,	Baltim	ore,	Md 21215	
3	Dhustalaa		23a. Partz. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final	cations that caused the death e cause on each line.	. Do not enter	r the mode of dy	ing, such as cardiac	or respiratory arre	est,	Approximate Interval Betw Onset and D	veen
3	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	ence of):	(4	7 (0			age	70)
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XO	leath certific ettending p	In/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar		Ectopic pregnanc			23d. Da	te of delivery	
O. B	the head	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de		Other (specify) _	-y		Mo	onth Day Y	ear
<u>α</u>	res that thigned by	by Ph	Part II. Other significant conditions con	tributing to death but not resu	Iting in the und	derlying cause gi	iven in Part I.	23e. Did tob	pacco use con	tribute to the cause of de	eath?
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Records,	ne taw r has be ge 2 sh	Completed						24a. Was a autops perforr	y	Were autopsy findings a prior to completion of ca death?	ivailable luse of
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Ž	Physicien: r this certifica ral director,	ToB	examiner?	ospital:	ER/Outpatient	3 DOA	han 1	lome 5 Reside		ner (Specify)	
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Ö	tel or A	Certi	4 Homicide	building, etc. (Specify)			City or Town	n, State)		
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medicai	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examinate	ician: To the best of my knowner: On the basis of examinat and manner stated.	vledge, death ion and/or inve	occurred at the testigation, in my	time, date and place opinion, death occu	e, and due to the coursed at the time, d	ause(s) and m ate and place,	anner as stated. and due to the cause(s)	
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)	1		· Kagur	1114		D4.	1617	/	794	17, 200	58
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10	Sta	ate	31. Date-filed (Month Day, Year)	32. Registrar's Signal	ure	roryk	19 Perci	1 Colui	5)/4/	- 1a 2107	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 Month HOPE 8:34 PM **Physician** 16 /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MARBORMOSPITAL BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept | 8 1 941 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Months **Funeral** 1 M 2 F 217-40-0282 66 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 ☐ No Anne Arundel Co. MD. Brooklyn Park Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21225 101 14th Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Examination. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No White Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) University of Md. Elementary/Secondary (0-12) College (1-4or 5+) School of Law Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sr. Doris Virginia Ford f. Shortt Robert ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Md. Baltimore. 21225 Fletcher Jackson, husband 101 14th Ave. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 5/20/08 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signature of Funeral Service Baltimore, Md. 21225 4001 Ritchie Hgwy 23a. Part1. Enter the disease, or complications that cause of he death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conse wence of Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal deal
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death Month Day Year in the past 12 months? 2 **2** No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ STAGE CHRONIC OBSTRUCTIVE 1 Tes 2 No 3 Probably 4 Unknown Be Completed MONARY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 perform 1 Yes 2 2 X No 1 TYes 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Mnpatient Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certifier

SOUTH HANDVER STREET BALTIMORE 2008 32. Registrar's Signature 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GAGARIN

29c. License number

ES-001

DMITRI

29d. Date signed (Month, Day, Year)

MAY 16,2008

GIAGARIN, MD

For

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

16345

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylanc Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1 - State Registrar Certificate of Death Reg. No.															
	1. Decedent's Name (First, Mid	dle, Last)			2. Date of Deat					th 3. Time of Death						
in	ARLENE	MARI	E	JACKSON	CKSON MAY					1 7	17 2008 5:00 p ^M) p ^M		
al	4a. Facility Name (If not institut.					Town, or	Location o	f Death				of Death				
er	8214 EDWILI	_				SEDA					BAI	TIM	ORE			
		6. Sex		n yrs. last birthday	7.1.		If Under 2	24 Hrs.	8. Date of Birt	h		9. Birthp	lace (State	or Foreign		
	5. Social Security Number 212364472	1 M 2	3-	9 Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day 0 3 / 29 /	/ Year)	30	Cour	YLAND	_		
									03/23/	10.	<u> </u>	(1111)				
	Usual Residence of Decedent 10a. State 10b. Coun	tv	10	Oc. City, Town or L	ocation							1	0d. Inside C	ity Limits		
_	Total olario	IMORE		ROSEDA									1 ☐ Yes	2 ∑ No		
ctc	MD BALT	IMORE		KOSEDA						10 0		1/2				
Ë	10e. Street and Number				10f. Zip	Code				10g. CI	tizen oi v	Vhat Cour	itry ?			
<u>=</u>	8214 EDWILI	AVE					21	1237					SA			
Je.	11. Marital Status		s Decedent Evened Forces?	r in U.S. 13	. Was Deced	lent of Hi	spanic Orig	gin? (Spo	ecify Yes or No- Rican, etc.)	.		e - Americ k, White,	can Indian, etc.			
盁	1 ☐ Never Married 2 📉 M.	arried 1 🗆	Yes 2 No		1 □Yes		Specify:	,	, , , , , , , , , , , , , , , , , , , ,	-	Specify		HITE			
ρ	3 ☐ Widowed 4 ☐ Divorce	ed Yea	es, Give ∆ ir or Dates:		10103 2		opcony.				Specify	· VV				
ted	15. Deced	ent's Education	(ata-t)	16a. Dec	edent's Usua	al Occupa	ation	t of worki	na	16b. K	(ind of B	usiness/In	dustry			
be	(Specify only high Elementary/Secondary (0-12		lege (1-4or 5+)	life.	e kind of wor DO NOT us	se retired)	i or worki	, ''g							
E	12	,	0	HA	IRDRE	SSEI	?			BE	AUT!	Y SA	LON			
Be Completed by Funeral Director	17. Father's Name (First, Middle	le, Last)					18. Mothe	er's Name	(First, Middle,	Maider	n Surnan	ne)				
9 B	GABRIEL	RE	BBERT				9	SOPE	IIA	P)	ETRI	LIK				
2	19a. Informant's Name/Relation	nshin (Type Prin	t) III OD I	19b. Mai	ilina Address	(Street a	and Numbe	er or Run	al Route Numbe	er, City	or Town,	State, Zij	Code)			
					14 ED	,			BALTIMO							
	WILLIAM A.	JACKSO	N Jr.				1 VAI		Date				own, State			
cemetery, crematory or other place)																
4 Donation 5 Other (Specify)								BALTIMORE, MD								
	21. Signature of Euneral Servi	ce Licensee			22. Name ar				CH/ROS							
		7			1211	CHI	ESAC	VA C	E BAL	CIM	ORE	, MD	2123	7		
	23a. Part 1. Enter the disease,	or complications	that caused th	e death. Do not e	nter the mod	de of dyin	g, such as	cardiac	or respiratory a	rrest,			Approxima Interval Be	etween		
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final development) Onset and Death Onset and Death Onset and Death Zyear										Death					
	disease or condition resulting in death)	a	Due to (or as a c	consequence of):	TAST	71)(UNC	1	, CC			-			
			or as a c	701100que1100 017.												
-	Sequentially list conditions, if any, leading to immediate	b	Due to (or as a o	consequence of):	sequence of):											
n/Medical Examiner	Cause (Disease or injury	<	,													
xar	that initiated events resulting in death) Last	c	Due to (or as a o	consequence of):	·											
쁘																
<u>i</u>		d														
Me	IF FEMALE:			-												
	23b. Was decedent pregnant in the past 12 months?		es, outcome of Live birth 2		th 3 Ectopic pregnancy					23d. Date of delivery Month Day Year			Year			
Sici	1 ☐ Yes 2 ☑ No		☐ Pregnant at ti ☐ Unknown	me of death	5 🗌 Other (s	pecify) _							,			
چ	9 ☐ Unknown										_					
Ž	Part II. Other significant cond	and the second of the second o	ag to dooth but		underlying o	ause giv	en in Part I	l.	23e. Did 1	tobacco			the cause o			
ğ	1	itions contributir	ig to death but	not resulting in the	, ,							3 □ Pro	bably 4 ☐	Unknown		
24a. Was a autop perfor									1 🗆	Yes 2	2 🗀 140	_	24a. Was an 24b, Were autopsy findings availate			
									24a. Was	an		Were aut	opsy finding	cause of		
mpk		aitions contribution	ig to death but	not resulting in the					24a. Was	an psy ormed?	24b.	Were aut prior to c death?	ompletion of			
Comple			ig to death but	not resulting in the					24a. Was auto perfo 1 □ Yes	an psy ormed? 2 4	24b.	Were aut	opsy finding ompletion of 2 No			
Be Comple	25. Was case referred to med examiner?	ical				Oth	or.		24a. Was auto perfo 1 □ Yes	an psy ormed? 2 4	24b.	Were aut prior to c death? 1 ☐ Yes	ompletion of			
To Be Comple	examiner? 1 ☐ Yes 2 ☐ No	ical Hospita	il: 1 ∐ Inpatieni	2 ☐ ER/Outpat	tient 3 □ D	OA Oth	er: 4 🗆 N		24a. Was auto performent of the control of the cont	an psy ormed? 2 A one)	24b.	Were aut prior to c death? 1 □ Yes	ompletion of			
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ation: To Be Comple	examiner? 1 Yes 2 100 27. Manner of Death 1 Natural 5 Per 2 Accident inve	Hospita 28a	il: 1	2 ☐ ER/Outpat 28b. Time Injur	eient 3 De	OA Oth 28c. Injur Wor	er: 4 □ N ryat	ursing H	24a. Was auto perfet 1 □ Yes th (Check only to perfect only to	an ppsy ormed? 2 (JK) one) idence how inj	24b.	Were aut prior to c death? 1 □ Yes ther (Spec	ompletion of 2 No			
tification: To Be Comple	examiner? 1 Yes 2 No 27. Manper of Death 1 Natural 5 Per 2 Accident inve 3 Suicide 6 Cou	Hospita 28a	il: 1	2 ER/Outpat 28b. Time Injur 4 - At home, farm,	eient 3 De	OA Oth 28c. Injur Wor	er: 4 □ N yat k?	ursing H	24a. Was auto performent of the control of the cont	an psy primed? 2 A none) idence how inj	6 On ury occu	Were aut prior to c death? 1 □ Yes ther (Spec	ompletion of 2 No	ımber,		
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Medical Certification: To Be Completed by Physicial	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per 2 Accident 3 Suicide 6 Cou 4 Homicide 29a. Certifier 1 Certi (Check only 2 Medi	ical Hospita Iding 28a Iding stigation 28e Idinot be ermined 28e Ifying Physician cal Examiner: O ar	a. Date of Injury (Month, Day, b. Place of Injury building, etc.	2 ER/Outpat Year) 28b. Time Injury - At home, farm, (Specify) my knowledge, de examination and/or	e of y M street, factor	OA Oth 28c. Injur Wor 1 □ y, office d at the tin, in my of	er: 4 🗆 N y at k? Yes 2 🗆	ursing He	24a. Was auto perfit 1 □ Yes th (Check only ome 5 □ XRes 28d. Describe 28f. Location (City or To	an psy primed? 2 (2 (Street a wn, State e cause , date a	6 □ Olury occu and Numite) (s) and r nd place Date sign	Were autiprior to codeath? 1 Yes ther (Special Period Per	ompletion of 2 In No 2	e(s)		

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year) MAY 2 0 2008

use of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Death

		1	= State Registrar			Cer	titicate of	Death		Re	g. No.	3 0	
	siciar edica	1	. Decedent's Name (First, Middle,		larise Joh	nsc	on		2.	Date of Deatl Month	Day 13, 20	Year)08	3. Time <i>o</i> f Death 1104 M
	mine		a. Facility Name (If not institution,		4b. City, Town, or Location of Death				4c. County	y of Death			
			Ann			Annap		L		Arundel			
Fune Direct	_	5	S. Social Security Number	5. Sex 1 □ M 2 🙀 F	7. Age (In yrs. last bir 79	thday) Yrs.	Months Days	If Under 2 Hours	4 Hrs. 8. Min.	Date of Birth (Month, Day, Jan 28		Cou	place (State or Foreign ntry) Maryland
D		- 1-	Jsual Residence of Decedent		10c. City, Tow		notice						10d. Inside City Limits
ING 21213-UU30 be filed within 72 hours after death with the Maryland ital Hygiene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		_	Maryland An	n or Loc		asadena	3				1 X Yes 2 □ No		
h the r 28		Directo	10e. Street and Number				10f. Zip Code			11	0g. Citizen of		
h wit			8134 Elizabeth Road					211	22			U.S	
deat		runeral	11. Marital Status	12. Was Dece Armed For	edent Ever in U.S.	13. V	Vas Decedent of I f Yes, specify Cub	lispanic Orig	in? (Specif	fy Yes or No- can, etc.)		ce - Ameri ack, White,	can Indian, , etc.
5-UU36 72 hours after 'natural', or Ite		≥	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:				I□Yes 2□ ≱ lo				Speci		Black
2 hou salura		Сотрыете	15. Decedent's	Education	16a	Deced	lent's Usual Occu	pation during most	of working		16b. Kind of E	Business/Ir	ndustry
ithin 7 nan "n Medi		ed -	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. E	kind of work done OO NOT use retire					Own	Home
d 2121 filed within Hygiene. ther than "		E O	12				Ho	memake					
Maryland '2' nd 2 should be filed w Ith and Mental Hygie 27 Is marked other ti		Re	17. Father's Name (First, Middle, L	ast)				18. Mother	r's Name (i	First, Middle, I			
should be marked o		0	Er	nest Kess							ina Kess		
Maryla d 2 should th and Men 7 Is marke		_	19a. Informant's Name/Relationsh	ip (Type. Print)	198		ng Address (Stree						ip Code)
			Peggie Kess			8	134 Elizabel	h Road F	Pasade	na, Maryla	nd 21122	2	
□ □ ⊥ 0 ÷		ı	20a. Method of Disposition		comete	f Dispo	sition (Name of natory or other pla	ice)	Dat	te	20c. Location	- City or T	own, State
			1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		State	-	on Church C		C	5/20/08	~	Pasade	na, Md.
Itin		+	21. Signature of Funeral Service 1		1		2. Name and Addr						
Baltimo	ouce		nall (685	Jer-		Estep	Brothers	Funera	al Service, timore, Me	P. A.		
		\dashv	23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that c	aused the leath. Do	not ent	er the mode of dy	EUTAW PI	ace Bar cardiac or	respiratory arr	3 2 1 2 1 7 — est,		Approximate Interval Between
Physici /Medic Examir	cai ner	ia ei	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):								Onset and Death		
certificate be executed ding physician and	ine Danal and	/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequence	of):		_					
Vital Records, P.O. Box (sician: The law requires that the death certificate has been signed by the attending	Colection use as	Physician/Me	- I Z3D, Was decedent pregnant I and the second of the sec									Date of deli Month	very Day Year
ds, P uires that	an an ni	2	1 ☐ Yes								co use contribute to the cause of death? 2 No 3 Probably 4 Unknown		
Division or Vital Records, at or Attending Physician: The law requires after death. Ultrector: After this certificate has been sign.	nous z añ	Completed									sy med?	prior to death?	topsy findings available completion of cause of
icate	, p		25. Was case referred to medical		1			26 Place	of Death	1 Yes (Check only o	2 No	1 ∐ Yes	20110
Sicla	Lectr	Be	examiner?	Hospital:	Inpatient 2 □ ER/C	utnatio	nt 3□ DOA O	thor:		ne 5 ☐ Resid)ther (Sna	cify)
or Vita Physician:	5	2	1 Yes 2 Ne	28a. Date		Time o	III JUDOA	4 🗆 NU		e 5 ⊔ Hesio 8d. Describe h			ony)
JIII After		0	1 _ Natural 5 □ Pendin	(Mor	nth, Day Year)	Injury			No				
or Attending of Attending of Attending of Attending	by me	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Str. City or Town)							mber or Ru	ural Route Number,		
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he	ely filled I	ledical Cer	(Check only 2 Medical	Examiner: On the b	e best of my knowled basis of examination a	ge, deat	th occurred at the	time, date ar	nd place, a	and due to the ed at the time,	cause(s) and date and plac	manner as	s stated. e to the cause(s)
To the h within 24	compie	Medi	29b. Signature and title of pertific	and mar	nner stated.		29c. Lice	nse number	14-		29d. Date sig	ned (Mont	h, Day, Year)
			1	MINU	1111			011	-17		0 0	113	/////
			30. Name and address of person		ise of death (Item 23a	Type,	, Prioft)	A	6	1-10.	100	1	M
			31 Date filed (Month, Day, Year)	1 N 3) (~ W	Registrar's Signature		11-17	· /V	V-/	1 /1 18	14/1/	11	

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month OYear **Physician** Koma 11m /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRCESTE cean Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Pay, Year) **Funeral** Months Days Min. Hours 218-22-128 1 □ M 2 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State ral", or items 23a or 28a-f shov 1 ☐ Yes 2 No Funeral Director arcest 10g. Citizen of What Country? 10f. Zip Code 10e et and Number a SA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Whit Be Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b, Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nom 01 marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၀ 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 other to nee 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If it any Injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Del Hic 4 Donation 5 Dother (Specify) BALTIMER 22. Name and Address of Facility Hasford NO 21. Signature of Funeral Service Licenses hapel- (23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure) List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaldisease renth , rend **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conseq Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ficate has been siç r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. W*a*s an autopsy performed? Yes 2 No the Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11107 recerract Rd., Berlin, MO

Registrar

State

0

2008

State Registrar 29b. Signatur

31. Date filed (Month, Day, Year) MAY 2 0

N. D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the within 2

DHMH 17 Rev 1/2001

EMMANUEL GOROSPE, ND/JUNG HOPKING BAYMEW MED. CTR./4990 EASTERN AVE, BALTIMURE, MD 21224

medical resident

29c. License number

RESOOI

29d. Date signed (Month, Day, Year)

MAY 10,2008

State of Maryland / Department of Health and Mental Hygiene 🤈 🍴 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 2008 Day **Physician** KETCHM ELIZABOTIL 9:30 p M MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5711 Cheshire Drive Montgomery Bethesda 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🕅 F Months Hours Director 145-46-3652 57 February 19,1951 New Jersey Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinating the notified at 10d. Inside City Limits 10a, State 10c. City, Town or Location 1 □Yes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 5711 Cheshire Drive Funeral 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher/Cantor Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter E. Foran Anne Mulherin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5711 Cheshire Drive, Bethesda, Maryland 20814 <u>Jeffery M. Ketchum/ Husband</u> 20b. Place of Disposition (Name of Monitory crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State May 19**,** 2008 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematorium Inc. Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 755/Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Fuperal Service Licenses M00335 23a. Part 1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. CHOLONG 10 CARCINO MA Immediate Cause (Final **Physician** METHSTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to himselfa cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequence of) requires that the death certificate be executed burial-transi Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 mon Month P.0. ed by the a 9 ☐ Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate Division of Vital 2 No 1 ☐Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 \$\frac{1}{M}\$ Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To Atter thi funeral o 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D29675 May 19, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boccia, M.D. Ralph V. 6420 Rockledge Drive, #4100, Bethesda, Maryland 20817-7847 32. Pagistrar's Signature 31. Date filed (Month State 0 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17^{ay} Physician MA Yonth 2008 BARBARA KIRSH 12:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 14415 CUBA ROAD COCKEYSVILLE BALTIMORE 8. Date of Birth (Month, Day, Year) 12/02/1938 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Months 1 □ M 2 🗙 F 216-36-1625 69 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 21 No MD BALTIMORE Director COCKEYSVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14415 CUBA ROAD 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) FINANCIAL CONSULTANT PLANNING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **BELAGA** MAURICE SALLY COLLIDGE ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NOEL KIRSH / HUSBAND 14415 CUBA ROAD, COCKEYSVILLE, MD Baltimore, 20b. Place of Disposition (Name of OHR ENE SSETH ISR ANSHE SFARD 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 05/19/2008 BALTIMORE, MD 4 ☐ Conation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final metastases Physician Brain disease or condition resulting in death) /Medical Due to (or as a consequence of) cancer of the lung Examiner 3 months Non-small Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) 9 months The law requires that the death certificate be executed Due to (or as a consequence of): physician the burial burial O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown signed by to ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>8</u> Diabetes mellitus type 2 1 Yes 2 No 3 Probably 4 Unknown Completed Hypertension 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate Aortic stenosis slp valve replacement death? 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

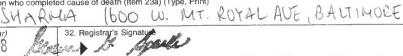
To the Funeral Director; Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0018410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #470 Lutherville, MD 21093 Falls Rd M Munford 10755 32. Registrar's Signature State 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimor es wick NULSING enter If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Months Days Hours 1 M 2 F 80 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County show r 28a-f show notified at Baltimore 1 Yes 2 No MD **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or Items 23a or 212 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 3 Widowed 4 Divorced Be Completed by Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur any injury or other traumatic event; the Medical! Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Lucy Am Smi 20a. Method of Disposition Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 16-08 auch nc. Greene Juneau Six 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): xaminer emen + Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use cooribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 V 0 3 Probably 4 Unknown 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 2 No 3□ DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient Certification: To 1 Yes this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After Injury 1 ☑Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours a er death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0064788 MD on who completed cause of death (Item 23a) (Type, Print) 30. Name an tackings

• 3

State Registrar 31. Date filed (Month, Day, Year) MAY 2 0 2008



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Physician 1:53 PM May 2008 Florence 19 Μ. /Medical Lee 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 1 1 Days 220-36-1045 67 Director 14 1941 N.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County N/A 1 ¥ Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1728 E. 30th Street by Funeral 21218 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2€NO Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) self employed 18. Mother's Name (First, Middle, Maiden Surname) 9th N/A Daycare 17. Father's Name (First, Middle, Last) Be Augustus Cheek Rosetta ဥ Crowell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Holland-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cem. 15 Western Winds Circle Baltimore, MD 21244 20a. Method of Disposition 20c. Location - City or Town, State 5/24/2008 Baltimore MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST lad Wane 1101 E. North Avenue Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Anoxic brain injury 13 days /Medical Due to (or as a consequence of): Examiner Cardial arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy pertorme rmed2 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 neral Blrector: After this filled in by the funeral d After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AT 24389 46 H13 MD

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

MO

Umon Memorial Hospital MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maurice

31. Date filed (Month, Day, Year)

Sheppard,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Year Physician May 19, 4:15 am Cora E. Lewis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore 1331 Burke Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Jan . 13, 1934 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 74 225-40-3484 Director TN Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore Baltimore MD 1 ☐ Yes XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21220 1331 Burke Road Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Sears Roebuck College (1-4or 5+) Sales 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sangster Arnold Elizabeth Eaves 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health a Important: If item 27 is any Injury or other tra Edward Lewis/ Husband 1331 Burke Road Baltimore, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 05/21/08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Septice Licenses 22. Name and Address of Facility 300 Mace Ave. Balto, MD 21221 Connelly Funeral Home of Essex Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Squanous **Physician** 5 Tonque disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 ☐ Other (specify) 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been signed 2 should b Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: ျ 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 302 RUDE 31. Date filed (Month, Pay State Registrar

			State of Maryland / Dep. State of Maryland / Dep. State of Maryland / Dep. 4.7 State of Maryland / Dep.	artment of Health and I /20/08dbb rtfficate of Death	Mental Hygie Reg	no. 2008 16354		
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death		
	Physicia /Medic		Angela A. Loftus		May	18 2008 5:27a M		
والمحاطب	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
, et t			Shanti House Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Laurel If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Prince George's 9. Birthplace (State or Foreign		
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M F 7. Age (In yrs. last birthday, 74 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y AUG 7 19	Pennsylvania		
			Usual Residence of Decedent		1100 / 13			
	ylanc how		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits		
	e Mar	cto	MD Prince George's Laurel			1 ☐ Yes 2 🔀 No		
	if the formal of	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?		
	s 23a	eral	7901 Laurel Lakes Court, Apt. 317	20707	pocific Voc or No	USA 14. Race - American Indian,		
	item:	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.		
936	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be redfiled at	ρ	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: White		
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21	thin 7 ne. nan "r	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		G. Garageman		
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Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene if Health and Mental Hyglene them 27 Is marked other than "natural", or items 23a or 28a-f show then traumatic event, the Medical Examiner must be retified at	Be	17. Father's Name (First, Middle, Last) Rocco Aicale	Carmel	,			
Ž	hould nd Me mark matic	٤		ing Address (Street and Number or Ru				
<u>8</u>	and 2 sho ealth and n 27 Is ma		* * * * * * * * * * * * * * * * * * * *	Laurel Lakes Cou	ct, Apt. 4	14, Laurel, MD 20707		
re,	s 1 ar	10	20a. Method of Disposition 20b. Place of Disposition cemetery, cre	osition (Name of matory or other place)	Date 20	c. Location - City or Town, State		
altimore,	Pages nent of int: If it iry or o			ematory, Inc. 5/19	9/2008 E	Baltimore, MD		
Balt	permit. Pages 1 an Department of Heal Important; If item 2 any injury or other once.		21. Signature of Funeral Service General. Williams	^{2.} Cremation of SacilitySoc 299 Frederick Ro	iety of M ad, Balti	aryland, Inc. more, MD 21228		
Т			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardia	or respiratory arres	Interval Between		
1	Physician	ō i	Immediate Cause (Final disease or condition Chronic Obstructi	ve Luna Disease		Onset and Death		
	/Medical		resulting in death) Due to (or as a consequence of):					
	Examiner	L	Sequentially list conditions, b.					
	red sit	Examiner	Sequentially list conditions, if any leading the following Cause. Enter Underlying Cause (Disease or injury					
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g	ilcian: The l certificate ha rector, page		Lung Carcinoma 25. Was case referred to medical	26 Plans of Do	1 □ Yes 2 1 ath (Check only one)	XINo 1 □ Yes 2 □ No		
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	To the within 2 To the comple	Me	29b. Signafure and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)		
	1- > F 0		Nabert H Levared MD	D0055522	Ma	y 19, 2008 19 May 2008		
	; 1		30. Name and address of person who completed cause of death (Item 23a) (Type					
	4		Robert H. Gereard, MD, 1500 Forest (Glen Road, Silver	Spring, M	D 20910		
	Sta Registi		31. Date filed (Worth Pay Year) 2008 Registrar's Signature	whi -				

				nd / Department of	Health and M	lental Hyg	iene	16355
	· · · · · · · · · · · · · · · · · · ·		1. Decedent's Name (First, Middle, Last)	Certificate of	Dealli	2. Date of Death	eg. No.	3. Time of Death
A.	Physici /Medic	al	, ,	UKASZCZY	K or Location of Death	MAY	Day Year 2008	11:10AM
	Examir	er	The Johns Hopkins Hospital	Baltimore			N/A	
Ť	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	J 9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent	Yrs. Months Days	Hours Min.	Apr. 1,	1962 Pen	nsylvania
	e Marylan 8a-f show tifled at	Director	10a. State 10b. County 10c. Ci	Ellicott	City			10d. Inside City Limits 1 ☐ Yes 2X No
	ath with th 23a or 2 ust be no	ral Dire	10e. Street and Number 4256 Hermitage Drive	10f. Zip-Code 21			og. Citizen of What Cou United Sta	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 M Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:	J.S. 13. Was Decedent of I If Yes, specify Cub 1 □ Yes 2 ▼No		ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
Baltimore, Maryland 21215-0036	vithin 72 ho ne. han "natur e Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire Electrical	during most of work d)	king	16b. Kind of Business/li	
7	iled v dygier ther to		12 5+ 17. Father's Name (First, Middle, Last)	Electrical		ne (First, Middle, M		
ylanc	ould be fi Mental H narked ot natic ever	To Be	Stanley Frank Lukaszczyk 19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street	Charlot	te Somme	rs	n Cada)
, Mai	and 2 sh ealth and n 27 is n ìe r traum		Stella C. Lukaszczyk - Wife	4256 Hermitag	ge Dr., E.	llicott(City, MD 21	.042
more	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1	Place of Disposition (Name of Precity, Ordinadiax Pla Cemetery	5 - 17	-2008	Woodlawn,	Maryland
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service Libensee				neral Home, rbutus, MD	
	Dhusisian		33 Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Immediate Cause (Final				est,	Approximate Interval Between Onset and Death
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Box 68	The law requires that the death certificate the has been signed by the attending physpage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Wo 9 □ Unknown 23c. If yes, outcome of pregnant at ime of continuous pregnant at time of continuous pregnant at	tal death 3 Ectopic pregnan-	су		23d. Date of deli	very Day Year
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Division of Vital Records, P.O.	ie law requ has been s ge 2 shoul	Completed				24a. Was an autops perforn	y prior to death?	opsy findings available completion of cause of
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o uoi	Attending Physician: or death. sctor: After this certification by the funeral director.		27. Manner of Death 1 ★ Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	28b. Time of 28c. Inju Wo M 1	ury at urk?] Yes 2 🗆 No	28d. Describe ha	w injury occurred	
Divis	To the Hospital or Attending Physician: The law within 24 buours after death. To the Funeral Director: After this certificate has i completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At h building, etc. (Specification)	nome, farm, street, factory, office ify)		28f. Location (St City or Town,	reet and Number or Ru , State)	ral Route Number,
	the Hospital or A thin 24 hours after the Funeral Direc mpletely filled in b	Medical C	29a. Certifier 1 Certifying Physician: To the best of my kno (check only one) 2 Medical Examiner: On the basis of examina and manner stated.					
	To the I within 2 To the I complex	Me	29b. Signature and title of certifier	29c. Licens	se number	29	9d. Date signed (Month	, Day, Year)
			MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Ite		000	N	1AY, 14,	2008
			ARUNA . S. RAO, JOHNS HOPKIN		600	North Wol	fe St, Baltimo	re, MD, 21287
	Sta Registi		24 D. J. Stand (Manufly Day Venus) 20 Registrario Signa					

			For State Registrar	State o	f Maryland		artment of H rtificate of L		Mental Hygio	ene	008	1635
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400	/Medic Examir		4a. Facility Name (If not institution,	,	mber)		4b. City, Town, or				y of Death	
r'	Funeral		5907 Halsey Road 5. Social Security Number 577–13–7413	1 . Sex 1 □ M 2 🛣 F	7. Age (In yrs. la	ast birthday) Yrs.	Rockvill If Under 1 Year Months Days	e If Under 24 Hrs Hours Min.	(Month, Day,	Year)	Coun	lace (State or Foreign
	Director		Usual Residence of Decedent 10a. State 10b. County			, Town or Lo	cation		June 1, 19	925	Chin	a. Od. Inside City Limits
	he Mary	Director	Maryland Montgo	mery	Roo	ckvill			1.00	g, Citizen of	What Caus	1 X Yes 2 □ No
	with i	Ωİ	5907 Halsey Road	1			10f. Zip Code 20851			ited :		•
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Extrainment by inclined at once.	Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie	12. Was Dece Armed Fo	2 🔀 No		Was Decedent of H f Yes, specify Cuba 1 □ Yes 2 \ No			14. Ra Bla	ice - Americ ack, White, e	an Indian, etc.
21215-0036	72 hours a natural", o	eted by	3 🌠 Widowed 4 □ Divorced 15. Decedent's (Specify only highest)			16a, Deced	dent's Usual Occup	Specify: ation	rkina 16	Speci 6b. Kind of E	ify: Asi Business/Inc	
2121	ed within ygiene. er than "	Completed	Elementary/Secondary (0-12)	College (1	1-4or 5+)	Homen	kind of work done of NOT use retired		0	wn Hor		
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lar)	2 sho v and I ls ma rauma	i l	19a. Informant's Name/Relationship		,	1	-		ural Route Number,			
e, ≥	1 and Health Sm 27 ther tr		Zeng-Hua Zhou / 20a. Method of Disposition	Son	20h Pli				kville, M	ary1aı Oc. Location		
Baltimore,	permit. Pages 1 Department of I Important: If ite any injury or ot once.		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)		of Hea	sition (Name of natory or other plac ven Cemeter	ry May 2	24, 2008 Si	ilver	Sprin	g, Maryland
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:	fo the Hospital within 24 hours в To the Funeral I completely filled	Medical	29a. Certifier 1	aminer: On the b	best of my know easis of examinati ner stated	rledge, death ion and/or in	n occurred at the tir vestigation, in my o	ne, date and plac pinion, death occi	e, and due to the cal urred at the time, dat	use(s) and r te and place	nanner as s , and due to	tated. the cause(s)
; I	Vithi To the	ž	29b. Signature and title of certifier				29c. License	e number	29	d. Date sign	ed (Month,	Day, Year)
			00 No.			4		053260	M	ay 19	2008	
			30. Name and address of person with Hon-Yuen Wong,			/		A, Rocky	ville, Mar	vland	20853	2
	Sta Registr		31. Date filed (Month Day Year)		egistrar's Signati	ure,	este o			,		

ORIGINAL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** m5-16 2008 William John Meyer, Sr. /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Washington Medical Center MY 8. Date of Birth (Month, Day, Year) 06-29-1928 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 220-24-0450 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 619 Marlboro Road 21061 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Electrical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John E. Meyers Elizabeth Troth ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a important: if Item 27 is any Injury or other trau 619 Marlboro Road; Glen Burnie, MD 21061 Mrs. Helen M. Meyer / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Cremation | 5/22/2008 Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licenses 1 2nd Ave SW; Glen Burnie, MD 21061 Services MC01357 23a. Part1. Enlegthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Can con Immediate Cause (Final mal Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an s certificate has be irector, page 2 s 1☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No npatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Year) (Month, Day Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident I Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide vithin 24 hours are
To the Funeral Dir X C-rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) siner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical Exa 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month Year **Physician** May 2008 60 /Medical 4h. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 80 e H05/I MOR Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Age (In yrs, last birthday) **Funeral** Months Days Hours Min. 1 M 2 □ F 6 05 Maryland Director 216-42-9830 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 3a or 28a-f show t be notified at 1 XYes 2 ☐ No MD N/A Baltimore Director Pages 1 and 2 should be filed within 72 hours after death with the I nent of Health and Mental Hygiene.
ant: If them 27 is anarked other than "natural", or items 23a or 28auny or other traumatic event, the Medical Examiner must be notifi 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21230 United States 2503 Lakeland Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) CNX Marine Elementary/Secondary (0-12) 12 College (1-4or 5+) Machinist Terminal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Granger B. Menefee Mildred C. Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Steven Menefee - Brother 324 Third Avenue, Lansdowne, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Arundel 20c. Location - City or Town, State Method of Disposition Burial 2 XCremation 3 □ Removal from State Ponation 5 Other (Specify) 5-17-2008 Odenton, MD Crematory 12. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Donot enter the mode of dying, such as cardiac or respiratory arrest, Arhythma Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner tey Disco ce Olarry Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) anding physician a use as the burial Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 0 9□Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 **D** No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? i or Attending Pafter death. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifie 29c. License number

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year MURDOCK **Physician** 09:10PM 05 6 2009 /Medical 4c. County of Dea titution, give street and number) Examiner 3AIti MUK If Under 1 Year | If Under 24 Hrs 9, Birthplace (State or Fpreign 6. Sex curity Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 M 2 F 5 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1. Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code Street and Number 14. Race - American Indian, Black, White etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) traumatic event, Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 Department of Health a Important; If Item 27 is any injury or other trai once. 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR Accisent , Physician ledical Due to (or as a consequence of): xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner inding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 2 Fetal death for Month Day Year I□Yes 2□No ed by the a 9□Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by 4 Unknown ANUTIL ENE COHMOPATHY 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No INSUFFICIENCY CHRONIC 2. ESPIRATORY 24a. Was an certificate has autopsy performe rmed No To the Hospital or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier HYSICIAN DU06453 16-MUSROW CICHIATRIC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Levings HOME 15ABATUNDE NURSING mi 31. Date filed (Month, Day, Year) gistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAY 20

2008

ORIGINAL

			State of Maryland / D 1 - State Registrar Amend Item 19b per fh, g879,	pepartment of Health and I	Mental Hygie							
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day 2008 3. Time of Death 10:33 PM						
-	/Medic		Martin Andrew Nueslein, Jr.	u on T and a fine of Dank		4c. County of Death						
	Examin	er	4a. Facility Name (If not institution, give street and number) Stella Maris	4b. City, Town, or Location of Death Timonium	1	Baltimore						
**	Euparal		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign						
	Funeral Director		40,400	Yrs. Months Days Hours Min.	Sept. 20	Year) 1915 MD MD						
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits						
	anylar shov	'n				1 ☐ Yes 2 ☑ No						
	the M	Director	MD Baltimore Parkto	01 10f. Zip Code	10	g. Citizen of What Country?						
	with sa or	<u>-</u>	19221 York Rd.	21120		USA						
	death ms 2;	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian, Black, White, etc.						
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, If a Midical Evaninar must be notified at once.	ğ	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 1 □ No 1 Yes, Give 1 Year or Dates:	1 ☐ Yes 2 ☐ No Specily:	o racari, etc./	Specify: white						
2-0	72 hou natura	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of wor		6b. Kind of Business/Industry						
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and	be fill he fill he ded ott	Be	17. Father's Name (First, Middle, Last) Martin Andrew Nueslein, Sr.	Cather								
Maryland	hould nd Me mark matic	ပ္										
Ma	nd 2 salth ar 27 is r trau	. v	Theresa Constance Hettchen/	Mailing Address (Street and Number or Ru 19221 YorkRd Parkt	on, MD 2	1120						
re,	is 1 an of Hea item		cemeter	Disposition (Name of y, crematory or other place)	Date 2	0c. Location - City or Town, State						
Ē	Page ment cant: If ant: If ury or				5/20/08	Baltimore, MD						
Baltimore,	permit. Departr Importa any inji		21. Signature of Fig. and Schools e Michael (J. Flagle	22. Name and Address of Facility Lemmon Funeral Hom 10 W. Padonia Rd.	ne of Dula	aney Valley, Inc.						
			23a. Part1. Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardia-	or respiratory arre	st, Approximate						
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Cresiname of the Example of the Exam									
	/Medical		resulting in death) Due to (or as a consequence of):									
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B	ires that the death certif signed by the attending I be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death	5 Other (specify)		Month Day Year						
P.0.	hat the		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?						
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ital		(D)	25. Was case referred to medical	26. Place of De	ath (Check only one							
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n o		Ë		Time of 28c. Injury at njury Work?	28d. Describe ho	w injury occurred						
sio	Attending it death. ector: After by the fune	cati	2 Accident investigation	M 1 □Yes 2 □No	Opt Location (C4)	met and Number or Dural Pouts Number						
Σ	or At after d Direct	Certification: To	4 Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, тастогу, опісе	City or Town	reet and Number or Rural Route Number, , State)						
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only Medical Examiner: On the basis of examination and the basis of the basis o	e, death occurred at the time, date and plac nd/or investigation, in my opinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner as stated. ate and place, and due to the cause(s)						
	thin 2 the mple	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number	25	9d. Date signed (Month, Day, Year)						
	F 2 F 8		Ruf J. Mu	29c. License number		5/18/2008						
J	/A		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)								
-	4		Robert T. Moss. M.D. 114	Business Center Dr.	, Reister	stown,MD 21136						
l.	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	artes								
	Regist	rar	MAY 2 0 2008 Aller A. Ag									

Villie Edward Pe		State of Maryland / Depa -For State Cer	Mental Hy		20	08 636		
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,Last))			Date of Death	g. No. n Day Year	3. Time of Death
Medical Examin	er	4a. Facility Name (if not institution, give street and number)	2884 h	lb. City, Town, or Lo	cation of Death	May 17, 20	4c. County of D	1820 hrs
		4000 Blk Pulaski Highway		Baltimore	cation of Beath		40. Godiny of E	Jean I
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth		J. Birthplace (State or oreign
Director	4	218-04-5835 1XM 20F	38 Yrs.	Months Days	Hours Min.	09/07	11969	Country) Bo Himre,
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Locati	on				10d. Inside City Limits
	٦	mo	Balt	more.				1 XYes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number		10f. Zip Code	piec.	10	g. Citizen of What	Country?
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5-0036 led within 72 hours after Hygiene. other than "natural",	E E	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		t's Usual Occupation ost of working life. D			16b. Kind of Busin	ness/Industry
D36 thin 72 ne. than " ledical J	Completed	12	Aircro	off Me	chani	·C_	Air	line
15-0 iled wi Hygier d other		17. Father's Name (First, Middle, Last)			Mother's Name	(First, Middle, M	laiden Surname)	
T. 5 6 8 9	F B	Willie L. Herry St. 19a. Informant's Name/Relationship (Tipe, Print)	19b. Mailing	Address (Street a	MOVY Ind Number or R	ural Route m	ber. City or Town.	State, Zip Code)
MD d 2 shot the and n 27 is rumatic		Cynthia L. Perry. Wife	108		zerne.	^	- 11.	noe, MD 21205
			Place of Dispos crematory or of	ition (Name of ceme ner place)	tery,	Date	20c. Location - Ci	ity or Town, State
그는 전 일 등 등 등		4 promotion 5 Other Specify:	tro C	reamator	45.	21-08	Bultin	nove, MO
Balt permit. Departi Importi	ļ	21. Specture of Funeral Survice Licensee	22. N	lame and Address of	Lane 1	well E	Baltim	Hone MD
Physician	7	23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.	. Do not enter th	ne mode of dying, su	ich as cardiac or	respiratory arre		Approximate Interval Between Onset and
/Medical	ĺ	Immediate Cause (Final disease a. Multiple Injuries						Death
		or condition resulting in death) Due to (or as a consequence of	f):					
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	ledical	IF FEMALE: 23c. If yes, outcome of pregi	nancy				23d. Date of de	divery
ox 6876(eath certificate : attending phys for use as the b		3b. Was decedent pregnant in the past 12 months?	2 Fe	tal death 3	Ectopic pregna	псу	Month	Day Year
Box 68760, e death certificate be the attending physic of for use as the burden burden at the burden	Physician/M	1 Yes 2 No 9 Unknown g Unknown	atri 5 Oti	her (Specify)			1	
. ž \ Ž	by Ph	Part II. Other significant conditions contributing to death but not re	esulting in the u	inderlying cause give	en in Part I.			ite to the cause of death?
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the saler death. The law requires that the scrifficate has been signed by led in by the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted.	edb					100000000000000000000000000000000000000		Probably 4 Unknown
Cord faw rec has bee	Completed					24a. Was a autops perfor	sy pric	ere autopsy findings available or to completion of cause of ath?
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical		26 Place of	f Death (Check o	1 ✓ Yes 2		Yes 2 No
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0 2		29a. Certifier 1 Certifying Physician: To the best of my knowledge	ge, death occur					
To the Ho within 24 To the Fe completel	Medical	one) 2 Medical Examiner: On the basis of examination at and manner stated. 29b. Signature and title of certifier	nd/or investigat	ion, in my opinion, d		the time, date a		to the cause(s) (Month, Day, Year)
	=	Sold Signature and the of Certifier		O.C.M.			May 18, 200	
	}	30. Name and address of person who completed cause of death (Item	23a)					
		Melissa Brassell, MD Assistant Medical Examir		enn Street, Bal	timore, MD	21201	_	
Sta Registr		31. Date filed (Month, Day, Year) MAY 2 0 2008 32. Registrar's Signatu	ire A	rocke				
	_							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 2 per dvr 9879 5-20-08 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 18 **Physician** 1: 10PM TEENTH 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPITAL SAMARITAN 4000 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 20 F Months 500 - 56 · 0342 Usual Residence of Decedent Hyderabad India 23 Director 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10b. County 1 Yes 2 No BALTIMOLE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA lendove by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Maryland 21215-0036 Specify: Indian 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ <u>G00000</u> Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. mDada Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State FOR FOREST HILL FOREST MILNID ZIOST 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee hapel - Gemation Services - Backer Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of) Examiner INFECTION FUNGAL Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. been signed to should be deta 23e. Did tobacco use contribute to the cause of death? þ MYDCARDIAL INFARCTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? CARDIOMYDPATHY 24a. Was an certificate has b irector, page 2 s autopsy perform METABOLIC ACIDOSIS Per RENAL AWITE 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Yes Impatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: Injury Vatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 8006 RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Blud, Baltimore. 5601 Roshan Dhawal loch MD alash 31. Date filed (Month, Day, Year) MAY 2 0 32 Registrar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7:50 A M Andrew Jennings Parker, Jr. May 16, 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Lorien Nursing Home of Mays Chapel Timonium 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days June 1, 1931 76 Maryland 216-28-6637 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Baltimore Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21286 USA 6 Beech Leaf Ct. 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 MYes 2 No If Yes, Give Year or Dates: 48-53 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Consulting Service 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Maier Andrew Jennings Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21286 Towson, MD Charlotte Parker/Wife Beech Leaf Ct. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 27, 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 21. Signature of Familia fichael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 8 Moute disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

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the Medical

Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, once.

Pages 1 and 2 should nent of Health and Men

death v

be filed within 72 hours after

altimore, Maryland 21215-0036

Director

Funeral

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Completed

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to the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the first or the completent of the filled in by the first or the filled in the first or the filled in the first or the filled in the first or the filled in the first or the filled in the first or the filled in the first or the filled in the first or the filled in the first or the filled in the first or the filled in the filled in the filled in the first or the filled in the filled i

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24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

23d. Date of delivery

Day

Month

Year

Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, does to examine the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Charles Street 6565 N. 32. Registrar's Signatur 31. Date filed (Month, Day, Year)

State Registrar

08-03776 Sharon Lynn Pilo Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Sharon Lynn Pilo		1- For State	ate of Mar	yland		artment of rtificate of			Menta	al Hy		g. No.	20	13	1636
Physicia	n/	Registrar 1. Decedent's Name (First, Middl	e,Last)			-				2	2. Date of Deat		Year		of Death
Medical Examin	ier	Sharon Lynn Pilo 4a. Facility Name (if not institution	n, give street and	(number)			b. City, To	um or L	nontion of		May 17, 20	008	ounty of D		0 hrs
		1311 Cedarcroft Road		i ridiliber j		"	Baltimo		ocation of	Death			V/A	eatti	
Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. I	ast birthday)	If Under		If Under		8. Date of Birt	h(MM/DE		. Birthplace (State or
Director		215-76-8527	1 M 2 X	F	41	Yrs.	Months	Days	Hours	Min.	01/03/	1967		Country)	MD
ź .		Usual Residence of Decedent 10a. State 10b. County			10c. City.	Town or Location	on .							10d. Ins	ide City Limits
id how a	_	MD N/A				timore								1	res 2 No
ne Maryland or 28a-f show any fied at once.	Director	10e. Street and Number					10f. Zip C	ode			10	g. Citizer	n of What	Country?	
	ä	1311 Cedarcroft	Road				21239)				U.S.A	Α.		
death with the or items 23a or must be notific	Funeral	11. Marital Status 1 Never Married 2 X Marital Never Married 2 X Marital Never Married 2 X Marital Never Married 2 X Marital Never Married 2 X Marital Never Married 2 X Marital Never Married 2 X Marital Never Married 2 X Marital Never Married 2 X Marital Never Married 2 X Married Never Married 2 X Married Never Married Nev		Decedent	Ever in U	.S. 13. Was		of Hispa	anic Origir Mexican, F	n? (Spe Puerto R	cify Yes or No-			merican India	ın, Black,
er dea			orced If Yes, Give		X No		Yes 2				,,			White	
urs aft tural" amine	a b	15. Decedent's Education (Spe	or Dates:		npleted)	16a. Decedent				nd of wo	rk done			ess/Industry	•
672 ho	lete	Elementary/Secondary (0-12)	Colleg	e (1-4 or :	5+)		st of worki	ng life. E	DO NOT u	se retire	d)				
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Completed	11	11 Disabled Father's Name (First, Middle, Last)												
115- e filed al Hyg ced oth	Be C	Vernon Weller,	Last)					18.Mother's Name (First, Middle, Maiden Surname) Margaret Nestor							
ore, MD 2121. Stand 2 should be fill of Health and Mental F If item 27 is marked her traumatic event,	임	19a. Informant's Name/Relations	a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (S									ber, City	or Town, S	State, Zip Coo	le)
MD id 2 sho lith and in 27 is	- 1	Margaret Weller,	edarcroft Road, Baltimore, 1												
of Hea	-1	20a. Method of Disposition 1 Burial 2 X Cremation	3 Remova	al from Sta	ate	Place of Disposit crematory or oth	er place)		,		Date			ty or Town, Si	tate
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Sp	pecify:		H	illtop Ser					20/2008				
Balt permit. Departs Import		21. Signature of Funeral Service Michael E. Canap)			ame and A				eonard J imore, M				
Physician	\dashv	23a. Part I. Enter the disease, or	complications the		the death										ximate Interval
/Medical	ı	failure. List only one cause Immediate Cause (Final disease	34 . 1	lone i	ntoxio	cation								Betwe	een Onset and Death
-Xammer	- 1	or condition resulting in death)	Due to (or a												
·	ᅵ	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	is a conse	equence o	rf):						_		_	
	튑	cause. Enter Underlying Cause (Disease or injury that initiated	C											1.5	
uted id ansit	dical Examine	events resulting in death) Last	Due to (or a	is a conse	equence o	π):								•	
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	Φ ⊩	IF FEMALE: 23b. Was decedent pregnant in th	23c. If y	es, outcor	ne of preg		11		7				Date of de	-	
Box 6876C e death certificate the attending physed for use as the b	sician/M	past 12 months?	1'="	/e bi rt h egnant at	time of de	ath -	al death er <i>(Specif</i>	3 <u> </u>	Ectopic	oregnan	су	M	onth	Day	Year
BO)	Physi	1 Yes 2 No 9 V Unk	known 9 Ur	known		0 011	er (opcon	"							_
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rs after death. It Director: After this certificate has been signed by the funeral director, page 2 should be detach.	e P	Part II. Other significant condit	ions contributin	g to deat	h but not r	esulting in the ur	nderlying o	ause giv	en in Part	I.				te to the caus	
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COLO	Completed										autop perfoi	sy med?		r to completic	on of cause of
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Vita ysiciai his cer directo	Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatie	ent 2	ER/Outpatient		10	ther.			Residenc	e 6 🗸	Other: Scene	
ding Ph. After t	일	27. Manner of Death		ate of Inju		28b. Time of In	jury 28	c. Injury	at Work?	72	28d. Describe I	now injury	occurred		
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bou hou		29a. Certifier									e, MD				
To the Ho within 24 Fu completely	Medical	(Check only one) 2 ✓ Medical Exam		sis of exa											s)
F F F 8	\$	29b. Signature and title of certifie		Sialeu.			29c. l	License	number	•		29d. Da	te signed	(Month, Day,	Year)
	- 1	Allen Bra	siell, 1.	ny				O.C.M	.E.			May 1	18, 2008	3	
V	Ī	30. Name and address of person			•	,	one Cir-	of De	ltim e	MD	1201				
Sta		Melissa Brassell, MD 31. Date filed (Month, Day, Year)	Assistant I		r's Signatu		enn Stre	ei, ba	mumore,	IVID 2	1201				
Registr	_	MAY Z'	2008	Berge	60 1	J. 1900	4								

OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** $5:45 p^{M}$ ERNEST RIVERS EDWARD 4 2008 /Medical MAY 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 225-52-8511 Director 68 VIRGINIA 1/8/1939 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director SPENCERVILLE MONTGOMERY MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with USA 20868 16104 OAK HILL RD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2X No Specify: Specify: BLACK \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) MERCHANT MARINE SEAMAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe 1 DAISY HARRIS NORFLETT RIVERS Pages 1 and 2 should traumatic ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any Injury or other traions. JEAN E. GREENE - SISTER 16104 OAK HILL RD, SPENCERVILLE, MD 20868 20b. Place of Disposition (Name of Cemetery, crematory or other place GATES OF HEAVEN CEMETERY 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/24/2008 SILVER SPRING, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 10220 GUILFORD RD, JESSUP, MD 20794 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** m.a disease or condition resulting in death) diac /Medical Due to (or as a consequence of): **Examiner** bleasclere if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.0. the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate Division of Vital 2 -No 2 🗆 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 1 Natural s after deu.
eral Director: Ar
er filled in by the 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide e Funeral I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the To the within 7 ed Direct 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO50410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Philip Dr. Olney MD 20832 31. Date filled (Month, Day, Year) egistrar's Signature State MAY 2 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mi	aryland / Dep <i>Ce</i>	rtificate of L			Reg. No.	008	15356
	Physici	. .	1. Decedent's Name (First, Middle	e, Last)				2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		BOISEY REED					MAY	12,	2008	9:30 P M
	Examin	er	4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, or	Location of Death		4c. Cour	ity of Death	
· Saraji			JOSEPH RITCHIE			BALTIMO	RE If Under 24 Hrs.	La But della		0.81-11	1000
ı	Funeral Director		5. Social Security Number 262–48–6257 Usual Residence of Decedent	6. Sex 7. Ag	e (In yrs. last birthday) 72 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day NOV • 2	y, _{Year)} 25, 193	Cour	place (State or Foreign htry)
	land		10a. State 10b. County		10c. City, Town or Le	ocation			-	1	0d. Inside City Limits
	Mary Ff sh	ţċ	MD		BALTIMOF	2F					1⊠XYes 2 □ No
	r 282	Director	10e. Street and Number		LA LLI LI TOI	10f. Zip Code			10g. Citizen o	of What Cour	ntry?
	h with		3827 CRESTLYN F	D.		21218			USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event har mat be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 XYes 2 ☐ If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hi If Yes, specity Cuba 1 □ Yes 2 🗷 No		ecify Yes or No- Rican, etc.)	14. R B	ace - Americ lack, White, o	etc.
21215-0036	thour	ed	15. Deceden		16a. Dece	edent's Usual Occupa	ation		16b. Kind of	Business/Inc	dustry
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D D	e file	Be (17. Father's Name (First, Middle,	Last)			18. Mother's Name	e (First, Middle,	Maiden Surna	ame)	
yla	ould b Ment arkec aric e	일	LEROY REED		1		PAULIN	E MOBLEY	Z		
ar	2 sho		19a. Informant's Name/Relations	hip (Type. Print)	19b. Maili	ing Address (Street a	and Number or Rui	ral Route Numbe	ər, City or Tow	n, State, Zip	Code)
ر ا	and fealth m 27 her tr		FREDA REED/WIFE	· · · · · · · · · · · · · · · · · · ·		27 CRESTLY				21218	
0	ges 1 If ite or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 ☐ Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	e)	Date	1080°S	UNRISE	BEACH RD.
Baltimore, Maryland	t. Pa rtmer rtant: rjury		4 □ Donation 5 □ Other (S			WNSVILLE	05/19	/2008	CROWNS	VILLE,	MD 21032
Bal	permi Depa Impo any is		21. Signature of Funeral Service	Chan Ja		2. Name and Addres 2007-09	eastern a				L. HM. 21231
			23a. Part 1. Enter the di er se, or shock, or heart fail ve. List	complications the caused only one cause on each lir	the death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory ar	rrest,		Approximate Interval Between Onset and Death
Supp.	Physician		Immediate Cause (Final disease or condition	_a. C.P	redium	yo o att	Y Y				Oriset and Death
	/Medical Examiner		resulting in death)		a consequence of):	1	/				
	_xummor	<u>.</u>	Sequentially list conditions,	b. Due to (or on	a consequence of):					_	
7	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence oi):					1,2	
	execu and al-trai	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):						
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89	± 00 €	edical		u.							
O. Box	The law requires that the death cert ate has been signed by the attendin page 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	/			Date of delive Month	ery Day Year
ď.	s that ned b deta	by Pl	Part II. Other significant condition	ons contributing to death b	ut not resulting in the L	underlying cause give	en in Part I.	23e. Did to	obacco use co	ontribute to t	he cause of death?
ğ	w requires that s been signed I should be deta							1□\	Yes 2 □ No	3 ☐ Prob	pably 4 👿 Unknown
l Records,	: The law recate has bee	Completed						24a. Was autop perfor 1 □ Yes	rmed?_	b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
Vital	sician; The certificate rector, page	Be	25. Was case referred to medical examiner?				26. Place of Deat				
	Physician; this certificaral director, p	၉	1 ☐ Yes 2 ☑ No		ent 2 ER/Outpatie		4 □ Nursing Ho	ome 5 Resid	dence 6 🗹	Other (Specia	mituspice
Ē	ng After Iner	Certification:	27. Manner of Death 1 Natural 5 ☐ Pendin	28a. Date of Inju (Month, Da	ry 28b. Time o y, <i>Year)</i> Injury	Work	:?	28d. Describe h	now injury occ	urred	
Division of	Vttendi death. ctor: A y the fu	icat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be	A4 h a sa a farma a4	- 1-	Yes 2□No	001			15 1 1
<u>></u>	= 5 # 6	Ħ	4 ☐ Homicide determ	ined building, et	ury - At home, farm, st c. <i>(Specify)</i>	reet, lactory, office		City or Tox	vn, State)	mber or Hun	al Route Number,
	spital ours ours ieral filled		29a. Certifier 1 Certifyir	g Physician: To the best	of my knowledge, dea	th occurred at the tir	ne, date and place	and due to the	cause(s) and	manner as	stated
	ne Hospital or Att n 24 hours after de ne Funeral Directe bletely filled in by t	Medical	(Check only 2 Medical one)	Examiner: On the basis o and manner sta	f examination and/or i	nvestigation, in my o	pinion, death occur	rred at the time,	date and plac	e, and due to	o the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of certifier			29c. License	number		29d. Date sig	ned (Month,	Day, Year)
	\		Desc M.	am, L		Dac	5877	1	Man	13.2	800
	271		30. Name and address of person	0,10	eath (Item 23a) (Type,					- 1	
	¥		DARIEUE ROBIN		38 NURTY	Eutow	23r 869	- Bald	inere	しいる	-yland
	Sta		31. Date filed (Manth, Day, Year)	2. Registr	ar's Si gnature	100					
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9:30pm

5/19/A

REES

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	_1	State Registrar			•	artment of F rtificate of		_	Reg. No.		1 2 0 0				
sicia		Decedent's Name (First, Middle, L.	ast)					2. Date of De Month	Dey	Year	3. Time of Death				
dica		William	L.		Robins	son, Sr.		5-18-2			11:56P				
mine	r '	4a. Facility Name (If not institution, gi Queen Anne's Cou			100		or Location of De	ath		y of Deeth					
al					lse last birthday)	Centrev		rs. 8. Date of Bir	4b	en Ann	1es lece (State or Foreig				
ı	1		123M 2□F	96	Yrs.	Months Days	Hours Mi		iv Year	Cour	ntry) NJ				
r		Usual Residence of Decedent						12 2/ 1	711	1	110				
		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limit				
	010	MD Queen A	nnes	Chu	ırch Hi	11					1 ☐ Yes 2 ☒ N				
1		10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?				
	a l	305 Crane Swamp				216			U.S.A.						
	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 X Yes 2 If Yes, Give Year or Date	os? □ No		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2점 No		(Specify Yes or No arto Rican, etc.)	Bla	ice - Americ ack, White, ify: Whi	etc.				
1	60	15. Decedent's E		J.	16a, Deced	dent's Usual Occup	pation		16b. Kind of E	Business/Inc	dustry				
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	E	Elementary/Secondary (0-12)	College (1-46	or 5+)	Accou	ıntant			Uti1	ities					
0	9 0	17. Father's Name (First, Middle, Las	t)				18. Mother's N	ame (First, Middle,	, Maiden Suma	me)					
	0	Walton Robinson					Mary	Marts							
ľ		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Address (Street	and Number or I	Ru <i>ral R</i> oute Numbe	er, City or Town	n, State, Zip	Code)				
l		Mrs. Nancy Seymon	ur / daug				e; Glen	Burnie,							
	2	20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 [☐Removal from Sta		lace of Dispo emetery, cren	sition (Name of natory or other place	ce)	Date	20c. Location	- City or To	wn, State				
l		*4 □ Donation 5 □ Other (Special				n Mem. P			Glen B						
		21. Signature of Funeral Service Lice	nsee					ingleton							
	4	23a. Pert1. Enter the disease, or con	anun			rvices		Ave SW; G		nie,	MD 21061				
physician and it is the burial-transit and leading lea	ĭ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequal	uence of):	0716,	HE 14167	PISEAS	<i>E</i>		BOYEH				
Dhyeirlan/Mad	ש ט	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Fetal at time of de	death 3	Ectopic pregnancy	1			ate of delive	ory Day Year				
9 74		Part II. Other significant conditions	contributing to death	but not resu	ulting in the un	nderlying cause giv	en in Part I.	23e. Did to	obacco use con	tribute to th	e cause of death?				
		ADVANCED 1	ACE					101	Yes 2 ☑ No	3 🗌 Prob	ably 4 □Unknown				
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4	0 2	25. Was case referred to medical					26. Place of D	eath (Check only o		7 4 7 6 3	1				
a	s	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa	itient 2 🗆 I	ER/Outpatient	t 3 DOA Oth	or	Home 5 Resid		her (Specify	HOSPICE				
ΙÀ		27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	njury Day Yeer)	28b. Time of Injury	28c. Injur Wor M 1 🗆		28d. Describe I			House				
I۲			289. Place of	Injury - At ho etc. <i>(Specif</i> y	me, farm, stre	eet, factory, office		28f. Location (S City or Tox		ber or Rura	l Route Number,				
Cartification: To	Columband	3 Suicide 6 Could not be determined	- Building,												
Certification: T		4 Homicide determined	hysician: To the be	of examinat	wledge, death ion and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)				
ЦÞ	2 2	4 Homicide determined	hysician: To the be miner: On the basis	stated.	ion and/or inv	29c. Licens	pinion, death occurrence	curred at the time,	date and place, 29d. Date signe	and due to	the cause(s) Dey, Year)				
Cartification: T	2 2	4 Homicide determined 29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Exa	hysician: To the be miner: On the basis	stated.	ion and/or inv	29c. Licens	pinion, death occurrence	curred at the time,	date and place, 29d. Date signe	and due to	the cause(s)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** Zas berge /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F POLAND **Funeral** Days 94 212-32-8539 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21209 3031 FALLSTAFF ROAD, APT. 4010 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 'natural", or items 1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 🕅 No WHITE Baltimore, Maryland 21215-0036 Specify. Specify: ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CLOTHING TAILOR permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: If iten 27 is marked other the any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be REITBERGER CHAYA **ISAAK** 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3031 FALLSTAFF ROAD, APT. 401C, BALTIMORE, MD21209 GUSTA REITBERGER / WIFE 20b. Place of Disposition (Name of ANSHE WUNAH or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 05/19/2008 BALTIMORE, MD
SOL LEVINSON & BROS., INC. 4 ☐ Donation 5 ☐ Other (Specify) AITZ CHAIM CONG. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Matt 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Cordovaxulas Duens Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 ☐ Unknown the funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 3 Probably 4 Unknown 1 ☐ Yes 2 🗖 🗓 🗓 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □ Yes 2 🕦 o Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient Certification: To 27. Manner of eath 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a To the Funeral C 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

State Registrar

29b. Signature and title of pertifier

ROL 31. Date filed (Month, Day, Year)

MAY 2 0 2008

29c. License number

29d. Date signed (Month, Day, Year)

8 2005

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amend Item: 8 per Info G-879 5/20/08 reb Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death P2 Physician 11:40 A_M May 2008 Genevieve M. Russo /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Regency Park Assisted Living Gambrills ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Oct. (Month, Day, Year) Nov. 17,1919 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Funeral Months Days Hours Min 1 □ M 2 XF MD 216-28-0581 88 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director ANNE ARUNDEL GAMBRILLS MD 28a-f 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 730 MARYLAND RT 3 SOUTH 21054 or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2 No altimore, Maryland 21215-0036 WHITE à 3 Widowed 4 Divorced Year or Dates: "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 8th College (1-4or 5+) MANUFACTURING ASSEMBLER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be if Health and Mental item 27 Is marked o GIUSSEPINA RUSSO JOHN RUSSO ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CROFTON, MD 21114 1530 ENDSLEY PL VICTORIA SCHMIDT-NIECE Important: If iten any injury or othe once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD 4 Donation 5 Other (Specify) HOLY REDEEMER 5/17/08 22. Name and Address of Facility CHARLES S. ZEILER & SON 21. Signa re of Fu nemi Service Licensee Baltimore, MD 21224 6224 Eastern Ave 23a Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hock, or heart tailure. List only one cause meach line. Imme The Couse (Fin I **Physician** disease or condition resulting in death) /Medical D e to (or as a consequence of) Examiner ng Securatelly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) anding physician a use as the burial-P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year signed by the a 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 → 3 Probably 4 Unknown 1 ☐ Yes After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 1 TYes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Pother (Specify 1 ☐ Yes 2 Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Mann f Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina spltal or Attendi lours after death. neral Director: A r filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital within 24 hours a 29a. Certifier f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number

State Registrar 10

Year)

9 2008

32. Registrar's S

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Vear 14 2008 2:31 PM May Daniel Joseph Sprehe M.D. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore Towson 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 2/21/1932 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1€M 2□ Oklahoma Director 444-28-4618 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be nutilled at 1 Yes 2 □ No Director Hillsborough Florida Tampa 10e. Street and Number 10f. Zip Code log Citizen of What Country? United States Of America 33629 2401 Ardson Place #203 B Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes XXNo Yes Give Specify. þ 3 ☐ Widowed 4 Ď Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Psychiatrist Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi Be Francis Louis Sprehe Stella Marie McGuire ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) Thomas G. Sprehe /Son 2112 Folkstone Road Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel - Rel Air Date 20c. Location - City or Town, State 20a Method of Disposition 16, 2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 21. Signatur, of Juneral Service Ligens 23a. Part1 /Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin... Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ing physician and e as the burial-trans Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) the ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy perform this certificate 2 No 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours arten control to the Funeral Director: Aftr Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

let

State 31. Date filed (Month, Day, Registrar

6701 N Charles Street
32. Repistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D57361

Towson Md 21204

State of Maryland / Department of Health and Mental Hygiene

		_	1 - For State Registrar	State of Mary		tificate of L		Re	g. No.2 0 0 8	16371
	Physici	an	1. Decedent's Name (First, Middle, Last) Louis George	Sahiossor	Tr			2. Date of Death Month May 13	Day Year	3. Time of Death 11:45a M
	/Medic Examir		4a. Facility Name (If not institution, give s		UI.	4b. City, Town, or	Location of Death	May 15	4c. County of Death	
1		٥	Future Care/ No			Eastp	oint		Baltimor	
4	Funeral Director		5. Social Security Number 6. Sex 216-12-7430 1X		yrs. last birthday) 6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 1	9. Birth Cou 4,1921 MI	place (State or Foreign ntry)
	yland low at		10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	e Man a-f sh tified	ctor	MD Baltimo	re	Es	sex				1 □ Yes XXNo
	ath with the 23a or 28 ust be no	ral Dire	10e. Street and Number 2328 Martin Dri	ve		10f. Zip Code 2122			g. Citizen of What Cou	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at ances.	Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 New 2 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 No	ispanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify. Whit	etc
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פ	al Hyg	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name		laiden Surname)	
yla	i Ment Marker Marker Marker	ဥ	Louis Schiesse		405 44-115-	and description of the same	Anna Jo		City Town Ctate 7	- O-d-1
, Mai	and 2 shealth and m 27 is n		19a. Informant's Name/Relationship (Ty, Lorraine Schies	ser/ Wife	2328	Martin	Drive 1	Baltimo	city or Town, State, Zi	1221
Baltimore,	. Pages 1 tment of H tant: If Ite Jury or ot		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	Sardens	of Fait	h 5/1	7/08 R	ossville	, MD
Ba	permit Depar Impor any In		21. Signature / Funeral Service Licers	KOND	Cc	Name and Address	Funeral	Mace Home o	Ave. Balt f Essex	21221
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the le cause on each line. Due to (or as a co	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death		
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):					
	cuted nd ransit	Examiner	that initiated events							
68760,	tificate be executed ig physician and as the burial-transit	ledical Ex	resulting in death) Last	Due to (or as a co	nsequence of):					
			IF FEMALE:	-						
.O. Box	that the death cer ed by the attendir detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome pf p 1□Live birth 2□ 4□Pregnant at time 9□Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	'		23d. Date of deliver Month	very Day Year
О.	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	by	Part II. Other significant conditions con	ntributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.		acco use contribute to	
Division or Vital Records,	The law rerate has bee page 2 short	Completed						24a. Was ar autops perform	/ prior to c	topsy findings available ompletion of cause of
<u>I</u>		Be C	25. Was case referred to medical examiner?				26. Place of Deatl			
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on	Attending I r death. ector: After by the funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye		Worl	k? Yes 2 □ No	Zod. Describe no	w filary occurred	
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	To the within 2 To the complete	Me	29b. Signature and title of certifier			29c. Licenso	e number	29	d. Date signed (Month	, Day, Year)
			► Mm			1007	ナンナ		2 116/08	Shir
	3		30. Name and address of person who co	harri	(Item 23a) (Type,	Waldh	en Woo	ds R	on Date signed (Montr	21234
	Sta Registi		31. Date filed (Month, Day, Year) MAY 2 0	32. Registrar's	Signature	boarte				

08-03736 Steven Scott Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

en Scott			State c	f Maryla	nd / Depar	tment of	Health	and	Mental	l Hygi			20	U8	1637
	R	- For State egistrar I. Decedent's Name (First, M	liddle Last)		Ceni	ificate of	Deain				Date of Deat			3. Time o	
Physicia dical Examir		Steven	Sco	H							Month May 16, 2		Year	0937	hrs
Mar.		a. Facility Name (if not insti	tution, give	street and nu	mber)		4b. City, Tow		cation of D	Death		4c. C	county of Deat	h	
		1102 Druid Hill Ave			=	1 5 3 5 4 5 3	BaltimD		If Under 2	AHrs 8	B. Date of Bir	th (MM/DI	D/YYYY) 9. Bi	rthplace (S	tate or
Funeral	- 1	5. Social Security Number	6. Sex		7. Age (In yrs. las		Months	Days	Hours	Min.	9-7-	_	I - orei	ignMan	yland
Director		215-60-506	8 1X	M 2 F	34	Yrs	·]			L	7	110			
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h with	Funeral	11. Mantal Status 1 Never Marned 2	Married	12. Was Dec Armed F	cedent Ever in U.S orces?	S. 13. Wa	as Decedent (es, specify	of Hisp Cuban,	Mexican, F	Puerto Ri	can, etc.)		White, etc.		-
	핊	3 Widowed 4		1 Yes If Yes, Giva Yes	2 X No	1	Yes 2	No.	specify:			8	Specify: 3	Jack	
rs afte ural", miner	画	15. Decedent's Education		or Dates		16a. Decede	nt's Usual O	ccupatio	on (Give ki	nd of wo	rk done	16b. Ki	nd of Busines	s/Industry	
72 hou "mat	etec	Elementary/Secondary (0			1-4 or 5+)				DO NOT 0	36 101110	u)	1	Wilde	NG	
5-0036 led within 7 Hygiene. I other than	Completed	12			2		Nelde	1	8 Mother's	Name (First, Middle	Maiden S	Surname)	- /_	
Filed w Hygid d other		17. Father's Name (First, M		Scor	11				Luc	ille	, Th	om	as		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	o Be	19a. Informant's Name/Rela	ationship (T					(Street	and Numb	per or Ru	ral Route No	umber, Cit	ty or Town, Sta	ate, Zip Coo	de)
MD 2 d 2 shou lth and 1 n 27 is 1	_	Jinika Se	off			4112		114	Ex 1	Kd.	Date	200 1	ocation - City	or Town, S	tate
re, ML s I and 2 s of Health a If item 27		20a. Method of Disposition 1 Bunal 2 Crer	mation 3	Removal	from State	Place of Dispo crematory or o	other place)						3		1
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Baltimore, permit. Pages I at Department of Her Important: If ite injury or other tr		21. Signature of Funeral S	ervice Licer	isee	1.	22	Name and	Address	or Pocility	glas	s Fun	erd L'm	Servi Servi	11. 21	217
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Physician /Medical		failure. List only one	cause on ea	acii iiiie.	erptic Cardip										Death
aminer		Immediate Cause (Final di or condition resulting in de			a consequence of										
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Division tal or Attendi safter death. sal Director:	ניין היין מיין יין	2 Accident	Investiga	ation 28e. F	Place of Injury - At	home, farm,	street, factor	y, office	building, e	etc.			and Number	or Rural Ro	oute Number, City
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	<u> </u>	1 /98. Certified 4	fying Phys	ician: To the	best of my knowl	edge, death o	ccurred at th	e time,	date and p	olace, an	d due to the	cause(s)	and manner a	s stated. e to the cau	se(s)
o the	Modical) i		ner:On the ba and mann	best of my knowless of examination er stated.	n and/or inves					at the time,	290	d. Date signed	(Month, D	Pay, Year)
H # H	Y N	29b. Signature and title of certifier 29c. License number O.C.M.E.									1	ay 17, 200		-	
		fiften B	l asse	4 111		220									
<i>'</i> h		30. Name and address of Melissa Brasse		no completed Assistant	cause of death (It Medical Exar	miner 11	1 Penn S	Street,	Baltimo	re, MD	21201				
مہ	Stat	Od Data Stad (Marath De			Registrar's Sign	noturo d	No								
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Michael J. Stepho	ens 1	Please Typ St For Stateamend #20th	ate of Maryland Or PER FH G88	Depar	tment of	Health and	Mental	Hygiene	20	08 1637
Physicia		egistrar 1. Decedent's Name (First, Midd		Cen	nicale or i	Dealii		2. Date of Death	g. No.	3. Time of Death
Medical Examir	ier	Michael Jero						Month May 12, 20	Day Year 008	0942 hrs
puls and	5.	4a. Facility Name (if not institution Bowie Health Center	on, give street and number)	44	o. City, Town, or Lo Bowie	ocation of De	ath	4c. County of De	1
Funeral		5. Social Security Number		ge (In yrs. las	.,	If Under 1 Year			h(MM/DD/YYYY) 9.	Birthplace (State or reign
Director		238-49-4464	1 M 2 F	3	9 _{Yrs.}	Months Days	Hours N	^{Min.} 09/24/	1968	Country) PA
any	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Fown or Location	n	-			10d. Inside City Limits
and show nee.	اة	MD How	ard		Columb					1 X Yes 2 No
with the Maryland ns 23a or 28a-f sh	Director	10e. Street and Number 6321 Early Gl	ow Court			10f. Zip Code 21045		10	og. Citizen of What C United S	
with the		11. Mantal Status	12. Was Deceden		6. 13. Was	Decedent of Hisp		(Specify Yes or No-	14. Race - Ar	merican Indian, Black,
r death	Funeral			? 2 No		s, specify Cuban,		erto Rican, etc.)	White, etc	lack
irs afte tural",	۾	3 Widowed 4 Div 15. Decedent's Education (Spe	vorced If Yes, Give Year or Dates: ecify only highest grade co	mpleted)	16a. Decedent	Yes 2 X No	n (Give kind	of work done	Specify: D	
6 72 hou an "nat	letec	Elementary/Secondary (0-12)	College (1-4 or	5+)		st of working life. I ical Cons			US Censu	c Bureau
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215- be filed mtal Hy rked of	8	Charles Stephe	ns					sy Wray		
D 21 should and Me 7 is man	۵	19a. Informant's Name/Relations Charles Stephe							ber, City or Town, S ain, NC 2	
e, M I and 2 Health item 2:	1	20a. Method of Disposition		20b. F			•	5/18 [#] /2008	20c. Location - Cit	
MOC Pages I nent of I		1 XBurial 2 Crematio 4 Donation 5 Other S		J.W	Gill &	Sons FH	-0	5/16/2008	Kings Mo	untain, NC
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Oppartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Juner Se i		101113		ame and Address		Harman F ive, Glen	uneral Se Burnie,	rvice, PA MD 21061
Physician	+	23a. Part I. Enter the disease, o failure. List only one cause	r complications that cause	ed the death.						Approximate Interval Between Onset and
/Medical / Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hypertensi			tic cardio	vascular	disease		Death
1		Sequentially list conditions,	Due to (or as a con b.	sequence of):					
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to for as a con	Sequence of	Y.					
ed Isit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
e executed ian and ial - transit		Xunpended	d. AMENDED.	MEL . C	70 5/20/	00 mm				
760, cate be physici the buri	/Med	IF FEMALE:	AMENDED #23a,27,1 23c. If yes, outcome	ome of pregr	Taricy		- 27		23d. Date of del	
Box 68760, e death certificate be the attending physicied for use as the buri	sician/Medical	23b. Was decedent pregnant in past 12 months?	4 Pregnant	at time of de	oth _	aldeath 3 ∟ ner(Specify)	Ectopic pre	egnancy	Month	Day Year
BO) ne death the att	Physi	1 Yes 2 No 9 Ur	9 Olikilowii	-4b b . 44			wan in Dort I	23e Did to	phacco use contribut	te to the cause of death?
P.O. es that the igned by be detach	≦	Part II. Other significant cond	ttions contributing to dea	ath but not re	esulting in the d	ndenying cause gi	ven in Fait i.			Probably 4 Unknown
Cords, P.O. law requires that has been signed b	Completed							24a. Was		re autopsy findings available r to completion of cause of
Recol The law icate has	dmo								rmed? dea	th? Yes 2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medic examiner?	11 11 1				Othor:	eck only one)	Decidence 6 1	Other:
1 of Vi ling Physi After this funeral dir	욘	1 Yes 2 No 27. Manner of Death	28a. Date of Ir (Month, Day		ER/Outpatient 28b. Time of In	o box	y at Work?	ursing Home 5 28d. Describe	Residence 6 (Juner:
ion c tending eath. tor: Af the fun	aţio		(Month, Day nding estigation	/,Year)		1_ Y	es 2 No			
Division of Vital Records, and or Attending Physician: The law requires after death. The The this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Co	uld not be 28e. Place of	Injury - At ho	ome, farm, stree	et, factory, office bi	uilding, etc.	28f. Location (or Town, 5		or Rural Route Number, City
Divis Hospital or A 24 hours after Funeral Dive		4 Homicide 29a. Certifier	ermined (Specify) Physician: To the best of	mv knowled	ge, death occur	red at the time, da	te and place,	, and due to the caus	se(s) and manner as	stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the filmeral director, page 2 should be detached for use as the buri	Medical	(Check only one) 2 Medical Ex	aminer:On the basis of ex	kamination a	nd/or investigat	ion, in my opinion,	death occur	red at the time, date	and place, and due	to the cause(s)
- > - 0	ž	29b. Signature and title of certif	ier <			29c. License O.C.N			29d. Date signed May 13, 2008	(Month, Day, Year)
		30. Name and address of person	on who completed cause o	f death (Item	23a)	0.0.1			1,, 2000	
<u> </u>		Ana Rubio MD. As	sistant Medical Exa	aminer	111 Penn S	Street, Baltimo	re, MD 21	1201		
Si Regis	tate trar	31. Date filed (Monta, D) y, Par	0 2008 32 32 32 30 is	trar's Signati	The state of					
	_				180					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician Day 5.15 PM JOHN G. SCHELLENSCHLAGER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GIEN AMME ARUNDEL BALTIMORE WASHINGTON MEDICAL CENTER BURNIE | Honder 1 Year | Honder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 28, 1950 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ■ M 2 □ F Months 214-54-8528 Director Maryland Usual Residence of Decedent 10b. County show 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experience mast by notified at Director 1 □Yes 2 No Marvland Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 1540 Palm Court 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify White If Yes, Give Year or Dates: þ 1 ☐Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. Iem 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Franki Foundation <u>Equipment Superintendent</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John William Schellenschlager Dorothy Myrtle Stauffort 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) <u>Veronica M. Schellenschlager</u> 1540 Palm Court, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 05 - 16 - 08Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. 5 fft.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) **Physician** HEART CONGESTIVE /Medical Due to (or as a consequence of): Examiner STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed · TIBALLATION TTRIAL burial-tran and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No After this of funeral dire 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu hours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and 29c. License number 29d, Date signed (Month, Day, Year)

Registrar

State

DHMH 17 Rev 1/2001

NABATO

MAY 2 0 2008

31. Date filed (Month, Day, Year)

Hospital drive

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Cameron Lee Sad			ate of Mary	land / I	Depart	ment of ficate of	Health Dooth	and	Menta	іі Нуд				
	R	For State egistrar . Decedent's Name (First, Midd	Un I not)		Certii	ilcate of	Deain			2.	Date of Deat	g. No. h		3. Time of Death
Physician Me Examin		Cameron Lee S									Month May 14, 20	Day 008	Year	2155 hrs
IVIC CAUTIN		a. Facility Name (if not institution	on, give street and	number)		4	o. City, To	vn, or Lo	cation of			4c. (County of Death	
		4806 Eades Street					Rockvil						ontgomery	haloss (State of
Funeral		. Social Security Number	6. Sex		(in yrs. last	birthday)	If Under Months	1 Year Days	If Under:	1.00			D/YYYY) 9. Birtl Foreign	n n untry) California
Director	ŀ	215-21-1246	1 X M 2 F	2	/	Yrs.	Wichard	Dayo			July 2	6, 1	980 Cou	intry) Call Tollian
	—	Jsual Residence of Decedent			nc City To	own or Location	on							10d. Inside City Limits
w any	- 1	10a. State 10b. County		1	Rocky									1 Yes 2 No
Maryland 28a-f show d at once.	ğΜ	aryland Montg	gomery		Rock		10f. Zip C	ode			1	0g. Citiz	en of What Cour	ntry?
or 28a	ie	aryland Montg 10e. Street and Number 4806 Eades Str	reet				2085	3			1	Unit	ed Stat	es
vith the Maryland s 23n or 28a-f shov 2 notified at once.	a	11. Marital Status	12. Was	Decedent E	ver in U.S	. 13. Wa	s Deceden	of Hisp	anic Origi	n? (Spec	cify Yes or No)-	14. Race - Ameri White, etc.	can Indian, Black,
eath w	Funeral		Married Armed	Forces?	No		es, specify			Риепо К	ican, etc.)			
ffer d	by F.		ivorced If Yes, Give	Үөаг			Yes 2						Specify: and of Business/	White
ours a	8	15. Decedent's Education (Sp					ost of work	ing life.	DO NOT L	ise retire	a)	1		
36 n 72 h nan "1	e e	Elementary/Secondary (0-12	2) Colleg	e (1-4 or 5	,	Client	Rela	tio	ns Ma	nage	r	Fir	nanciai	Consulting
withii withii giene.	Completed	17. Father's Name (First, Midd	le, Last)								First, Middle,		Surname)	
215. e filec tal Hy ked o	Be	John R. Sacket									labeck			77-0-43
213 ould b d Men s marlic eve	.0	19a. Informant's Name/Relatio	nship (Type, Print)	-1		19b. Mailin	Address	(Street	and Num	ber or Ru	ıral Route Nu Atasca	mber, Ci Lder (ity or Town, State O, CA 93	6422
MD d 2 sh lth and n 27 i aumad		Cheryle L. Sac	kett / M	otner	20h B	lace of Dispos					Date	20c.	Location - City o	r Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 X Burial 2 Cremati	ion 3 Remov	al from Sta	to CI	rematory or ot	her place)			May 2	24. 2008	Roc	kville,	Maryland
imo Page ment (4 Donation 5 Other	Specify		Park	Lawn Men	DI Tal	Address	of Facility		F	1 116	me /Rock	ville. Inc.
Salt bermit. Depart mpor njury		21. Signature of Funeral Service	ce Licensee	мО	0896	Ro 30	bert O W.	A. I	rumpn gome	rey ry A	ve., F	locky	ville, M	ville, Inc. ID 20850
ysician		23a. Part I. Enter the disease,	or complications th	nat caused	the death.	Do not enter	the mode o	f dying,	such as c	ardiac or	respiratory a	rrest, sh	ock, or heart	Approximate Interval Between Onset and
/ledical		failure. List only specau Immediate Cause (Final disea	ise on each line.			d of Head			_					Death
Examiner		or condition resulting in death		as a conse										
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tal Rectian: The certificate ector, page	ပြ	25. Was case referred to me	dical					26.Plac	e of Death	(Check	only one)			
Vital hysician this cert	o Be	examiner? 1 ✓ Yes 2 No	Hospital:	Inpati	ent 2	ER/Outpatie	nt 3	DOA	Other ₄	Nursin	ng Home 5		dence 6 🗸 Ot	her: Scene
n of Vital Recing Physician: The lafter this certificate lineral director, page	=	27 Manner of Death	28a.	Date of Inj (Month, Day, UND:	jury Year)	28b. Time o	f Injury	_	ury at Wo	_	28d. Descri Subject s	be how i hot se	njury occurred If	
ion reath. or: A	ļ į	1 Natural 5 1	Pending Ma	v 14. 200	8	FOUND: 2148 hrs		-	Yes 2 ▼					Rural Route Number, City
Division of Vital Records, tal or Attending Physician: The law requirents after death. In Director: After this certificate has been signed in by the fineral director, page 2 should be led in by the fineral director, page 2 should be appeared of the control of	از ا	3 V Suicide 6	Could not be 286			nome, farm, st	reet, factor	y, office	building,	etc.	or Tow	m Ctotal	et, Rockville, M	
Divis spital or At nours after d	Certification:	4 Homicide		ecify) Si		10000		o time	tate and "	nlare are	d due to the r	ause(s)	and manner as s	stated.
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To the To	Medical	29b. Signature and title of ce	anuma	nner stated	-/-				nse numbe			29	d. Date signed ((Month, Day, Year)
	[1/1/11	111	5	1)	O.C.M.E. May 15, 2008							
	1	30. Name and address of pe	erson who complete	cause of	death (Ite	m 23a)								
		Zabiullah Ali, M.D.	Assistant N	/ledical B	Examine	er 111 P	enn Stre	et, Ba	Itimore,	, MD 2	1201			
	Stat	INTERNAL TO THE PARTY OF THE PA	2 0 2008	32. R gist	rar's Signa	iture.	Seed.	,					OCME	

			State Registrar	te of Maryland / Depa	artment of I			giene 006	16376
	Physici /Medio		1. Decedent's Name (First, Middle, Last) GeneVa	Thompso	n		2. Date of Dea Month	14th 2008	3. Time of Death 8 · 30p M
	Examir		4a. Facility Name (If not institution, give street a Good Samaritan 5. Social Security Number 6. Sex		4b. City, Town, Baltim If Under 1 Year		V	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 214-14-8587	7. Age (In yrs. last birthday) X 85 Yrs.	Months Days		Min. (Month, Day	9. Bir -1923	thplace (State or Foreign ountry) MD
Maryland	r 28a-f show	ctor	10a. State 10b. County N/A	10c. City, Town or Lo					10d. Inside City Limits 1 ✓ Yes 2 □ No
deeth with the	ne 23a or 2	Funeral Director	1712 N. Caroline 1712 N. Caroline		10f. Zip Code	21213		USA	
5-0036	or Ite	by	1 Never Married 2 Married 1 tf Y	Yes 21X No	was Decedent of the Yes, specify Cub		in? (Specify Yes or No- Puerto Rican, etc.)	Black, Whi	te, etc.
21215-C	Medic	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) 11th grade	leted) (Give life. I	dent's Usual Occu kind of work done DO NOT use retire	e durina most i	of working	16b. Kind of Business Dept of	Undustry Balto Education
Maryland	I Health and Mental Hygien Itam 27 Is marked other the other traumatic avent, Itam	To Be C	17. Father's Name (First, Middle, Last) Robert Davis	,		Mabl	's Name <i>(First, Middle,</i> e Bouldir	1	
	aalth and n 27 la m er traum		19a. Informant's Name/Relationship (Type, Prii Raymond E. Thomps	on 171			or Rural Route Numbe e Street		
Baltimore	ment o ant: if ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, crer Greenmo	natory`or other pla		Date -26-2008	20c. Location - City or Baltimor	
Bal	Depert Import any in		21. Signature of Funeral Service Licensee	'/H East Balto, M	D 21202				
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O. Box 68	e etter	Physician/Med	in the past 12 months?		Ectopic pregnanc	су		23d. Date of de Month	livery Day Year
O E	been signed b should be deta	ρ	Part II. Other significant conditions contributin	g to death but not resulting in the ur	nderlying cause gr	iven in Part I.		obacco use contribute to	o the cause of death?
œ ª	ate ha	Completed					24a. Was a autop perfor 1 Tyes	sy prior to	utopsy findings available completion of cause of
of Vital	is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital	1 Inpatient 2 ER/Outpatien	t 3 DOA Ott	100.000	of Death Check only or sing Home 5 Resid		aniful
Division of	After fune	Certification: 1	27. Manner of Death 1 Shatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Date of Injury (Month, Day Year) Place of Injury - At home, farm, str	28c. Inju Wo M 1	uryat ork?]Yes 2 □ N	28d. Describe h	ow injury occurred	
5 6	i C i		4 Homicide	building, etc. (Specify) To the best of my knowledge, death			City or Tow	n, State)	
To the Hospital	vithin 24 h o the Fu ompletely	Medical	(Check only 2 Medical Examiner: On	the basis of examination and/or ind manner stated.	vestigation, in my o	opinion, death	occurred at the time, o	date and place, and du	e to the cause(s)
	21-0	1	30. Name and address of person who complete	d cause of death (Hem 23a) (Tune	Print)	306	6/	Hay 15	12008
			560/ Loch Kaver	- Blvd. 1	Ballis	nole	· Md-	2123	,
	Sta Registr	ar	31. Date filed (Month, Day, Year) MAY 2 0 200	32. Registrar's Signature	Sporte				

				For State Registrar	State o	of Maryla	•	artmer ertifica				lental Hy	giene Reg. No. 2	008	16	377
		Physici		1. Decedent's Name (First, Midd Dorothy C. To								2. Date of De Month May	ath Day 13	2008	3. Time of 6:45	
	and the	/Medio		4a. Facility Name (If not institution		mber)		4b. City	Town, o	r Location	of Death	1147		ounty of Death		
		Lamin		Suburban Hos	pital			Bet	hesd	a			Mon	tgomery	7	
		Funeral		5. Social Security Number	6. Sex 1 □ M 2 🛣 F		s. last birthday	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Oct. 20	th iy, Year)	Cou	place (State ontry)	or Foreign
		Director		212-10-0019		94	Yrs.					Oct. 20	1913	Mary.	Land	
		and and		Usual Residence of Decedent 10a. State 10b. County	,	10c.	City, Town or L	ocation						1	0d. Inside C	ity Limits
		Maryl f sho	ğ	Maryland Monts	gomery	Ro	ckville	2							1X Yes	2 🗆 No
		the l	Director	10e. Street and Number	50mery	100	CICVILLE		p Code				10g. Citize	n of What Cou	ntry?	
		h with	<u>=</u>	407 Crooked Cre	eek Drive			20	0850			t	Jnited	State	S	
		hours after death with the Maryland tural", or items 23a or 28a-f show it Examinat remate enceffind a	Funeral	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was Dece	dent of H	lispanic Or	igin? (Sp	ecify Yes or No Rican, etc.)	- 14	. Race - Ameri Black, White,		
	98	or ite		1 ☐ Never Married 2 ☐ Mai	161/00 0	2 X No ive		1 □Yes		Specify:		Thousand Story		pecify: Whi		
	8	ural",	d by	3 X Widowed 4 ☐ Divorced	Year or C	Dates:				-41				of Business/In		
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5	p	illed Il Hyg other	Q)	17. Father's Name (First, Middle	, Last)					18. Moth	er's Nam	e (First, Middle	, Maiden Su	ırname)		
a	ם	Aenta Aenta rked	10 B	William A. Ca	rson					Cha	rlot	te Buhl				
645pm	lar	id 2 should be filed within 72 hours after the and Mental Hygiene. 27 is marked other than "natural", or ite trauma" c event, tre Waifel Examina		19a. Informant's Name/Relation	ship (Type. Print)							ral Route Numb				
7.	Σ	and and and and and and and and and and		Marion T. Sil	va / Daugl					reek		e, Rock				0850
9	ore	Jes 1 t of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐ Removal from	State T o	Place of Disp cemetery, cre rraine	osition (Na ematory or Dowle	me of other plac	ce)		Date 19 , 2008		tion - City or To		
0	Ë	. Pag tmen tant: jury		4 □ Donation 5 MOther (3	Specify)Entombme	ent Ce	matami			- 1	-		Woodla	awn, Ma	ryland	
23	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any njury or other traumafle evone.		21. Signature of Funeral Service	Licensee	MO	1360	22. Name a nc. 30 0850-21	nd Addre 10 Wes 305	ss of Facili t Mont	gomer	ert A.Pun y Avenue,	Rockv	ille, Ma	ryland	cville
347		Physician		23a. Part 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition	r complications that to tonly one cause on	each line.				_		or respiratory a			Approximat Interval Be Onset and	tween
3	-	/Medical Examiner		resulting in death)	Due to	(or as a cons	equence of):									
3	_	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	b. Due to	(or as a cons	equence of):									
10		cate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c	(or as a cons	equence of):									
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\	89	tificat g phy as the	a)													
thi	O. Bøx	The law requires that the death certificate be executed ate has been signed by the attending physician and oxage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	itcome of preg birth 2□Fi gnant at time o nown	etal death 3	☐ Ectopic ☐ Other (s		су			23	d. Date of deliv Month	,	Year
9	σ.	that the	/ Ph	Part II. Other significant condit	ions contributing to d	leath but not r	esulting in the	underlying	cause giv	en in Part	1.	23e. Did	tobacco use	contribute to	the cause of	death?
\$	of Vital Records	luires n sign Ild be	d by									1 🗆	Yes 2	Ño 3□ Pro	bably 4□	Unknown
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-	æ	The law ate has page 2 s	E										ormed?	prior to co death? 1 ☐ Yes	mpletion of o	cause of
-	ta	i cian : The certificate ector, pag	(a)	25. Was case referred to medica	al					26. Plac	e of Dea	1 □Yes th (Check only	2 No No	I L Yes	2 L S N0	
by		is is	OB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	Anpatient 2	☐ ER/Outpati	ent 3 🗆 🖸	OA Oth	ner: 4 🗆 N	lursing H	ome 5 ☐ Res	idence 6	☐Other (Spec	ify)	
		ding Ph h. After th funeral	١Ë	27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Date	of Injury	28b. Time Injury	of	28c. Inju Wor	ry at 'k?		28d. Describe	how injury	occurred		
7.7	<u>S</u> i	Attending r death. ector: After by the fune	äţic	2 Accident invest	ligation			М		Yes 2	No					
6,	Division	or Att	Certification: To		mined 286. Place	e of Injury - At ling, etc. <i>(Spe</i>	home, farm, s cify)	treet, facto	ry, office				(Street and wn, State)	Number or Rui	al Route Nur	nber,
+	, 🗆	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	ledical Ce		ing Physician: To the											s)
		the ithin ithe	Mec	29b. Signature and title of certific		mer stated.		2:	c. Licens	se number			29d. Date	signed (Month	Day, Year)	
4		vit To		> 7	un Be	200	20		00	05	21:	24	5	1141	107	
				30. Name and address of person	n who completed cau	ise of death (I	tem 23a) (Type	e, Print)						-	•	
				Truong Bao M.I					ve #2	201,	Rock	ville,	Mary1	and 208	50	
	ŧ	Sta	ate	31. Date filed (Mgnth, Par Year		Registrar's Sig		- 00								
		Registi	rar		-000	was s	OF AND	MA								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 10:45p^M MAY 2008 THURMON LEE WILLIAMS 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SEASONS HOSPICE RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Securify Number 7. Age (In vrs. last birthday) **Funeral** 1 □XM 2 □ F 9/23/1941 409-60-9893 66 Director SOUTH CAROLINA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show tems 23a or 28a-f show 1 XYes 2 □ No **Funeral Director** BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21213 USA 3442 KENYON AVE 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 Never Married 2 Married 1 ☐ Yes 2X No Specify If Yes, Give Year or Dates: Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) CONSTRUCTION WORKER CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Mental and 2 should be and Mental GLADYS TAYLOR JOSEPH WILLIAMS ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 i KENYON AVE, BALTIMORE, MD 21213 DELORES WILLIAMS other permit. Pages 1 and Department of Heal Important: If Item 2 any Injury or other Once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/17/08 4 🗀 Donation 5 ☐ Other (Specify) CEMETERY BALTIMORE, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21. Signature of Funeral Service Licenses 4600 LIBERTY HEIGHTS AVE, BALTIMORE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** I GRMINM disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence off Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last /sician and e burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 \square No 1 ☐ Yes 2 ☐ No 1 TYes 25. Was case referred to medical 26. Place of Death /Check only one Be Certification: To

Ö Vital Records. ð Division after death.

Director: A
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To the Fune

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examiner? 1 ☐ Yes 2 ☐ N	lo	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 1	OOA Other: 4 I Nursing H	lome 5 Residence	6 Other (Specify)	050:C
27. Manny of Death 1 Vatural 2 Accident	5 Pending investigation		28b. Time of Injury	M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred	-
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, stree fy)	t, facto	ory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route te)	Number,

(Check only one) 29b. Signature and title of certifier

29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

120 operah Cl 32. Registrar's Signature 31. Date filed (Month, Day, Year)

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

Medical





Angels M. Whitlingloss
08-03729 Please Ty

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 16379

JNK UNK		-For State Criticate of Death	Reg. No.
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	Date of Death 3. Time of Death
Medical Examin	ner	Angelo M. Whittington	May 16, 2008 0225 hrs
*	•	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dec	eath 4c. County of Death Baltimpre County
		Timadelpria read at vinices. Very	
Funeral Director		218-11-0577 1X M 2 F 22 Yrs. Months Days Hours M	Min. 4-24-1986 Foreign Country) MD
any		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location	10d. Inside City Limits
≱		MD Baltimore Essex	1 Yes 2 X No
arylan 8a-f s	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
the M a or 2		938 Foxridge Lane 21221	USA
Baltimore, MD 21215-0036 permit - Pages I and 2 should be filed within 72 hours after death with the Maryland permit - Pages I and 2 should be filed within 72 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	
ifter d	E	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	Specify: Black
lours a		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	I of work done 16b. Kind of Business/Industry eretired)
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5-0036 led within 7 Hygiene. I other than	Completed by	· · · · · · · · · · · · · · · · · · ·	lame (First, Middle, Maiden Surname)
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2121 ould be fi d Mental s marked lic event,	힏		r or Rural Route Number, City or Town, State, Zip Code)
MD d 2 sho Ith and n 27 is		William Whittington, Jr. 1	ane Essex, MD 21221 Date 20c. Location - City or Town, State
ore, s 1 an of Hea of Hea		Crematory or other place)	
imC Page ment tant:		4 Donation 5 Other Specify:	/24/2008 Randallstown MD
Baltimore, permit. Pages I a Department of He Important: If it		Market 12 market 1101 E. North	MARCH FUNERAL HOME-EAST Avenue Baltimore, MD 2120
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardifailure. List only one cause on each line.	iac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Deali
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	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
	Examiner	Cities or injury that initiated events resulting in death) Last of events resulting in events resulting resulting in events resulting in events resulting in events resulting re	
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e exec cian ar	Medical	UNPENDED X AMENDED Item#9, perFH, 0879, 5/22/08, WS	
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery regnancy Month Day Year
Box 687 death certific the attending p	sician/	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (Specify)	regnancy Month Day real
Box death	ysi	1 Yes 2 No 9 Unknown 9 Unknown	
D. hat the ed by the betache	y Phy	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown
tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach	ed by		24a. Was an 24b. Were autopsy findings available
of Vital Records, ng Physician: The law requir Net this certificate has been s meral director, page 2 should	ompleted		autopsy performed?
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tal Financertiff	BeC	25. Was case referred to medical examiner? Hospital: 1 Innatient 2 FR/Outpatient 3 DDA Other; 1 DDA	
F Vit Physic rathis	0	1 Yes 2 No	Nursing Home 5 Residence 6 Other: Scene 28d. Describe how injury occurred
n O' ding h. : Afte	on:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Mgnth, Day Year) May 16, 2008 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 ✓ N	Driver of auto involved in collision
Sio Atten r deat ector by the	icati	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Division tal or Attendin rs after death. ral Director: A	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street	or Town, State) Philadelphia Road at Windsor Way, Rosedale, MD
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	e, and due to the cause(s) and manner as stated.
o the vithin of the omple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	
F s F S	ž	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
		O.C.M.E.	May 16, 2008
		30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, M	ID 21201
	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	
S Regis	tate strar	BERLY O O COCC File All Manual	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner timore OWS Or If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 M F Months Days Min Hours Yrs Prettimore MI 1699 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evanther must be notified anone. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Funeral Director More 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 234 0 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 3 Widowed 4 Divorced WILL Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) a ORD 0 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be reorge ပ 19a. Informant's Name/Relationship (Type. rint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ML 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition 1🙇 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 DOther (Specify) 11monium, MI 22. Name and Address of Facility 8800 H OPD RD. BALTIMORE MOZIZAL. 21. Signature of Funeral Service Licenses Do not enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part 1. Enter the disease, ir complication, that caused the deal shock, or heart failure. List only one course on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or a the Hospital or Attending Physician; The law requires that the death certificate be executed ng physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending t completely filled in by the funeral director, page 2 should be detached for use as IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 4 Doknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 | Yes 2 | 1 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 INatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated a medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). 29a. Certifier and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marner state 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier License number

State Registrar 30. Name and address of per-

Akkad

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deal (flem 23a) (Type, Print)

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Registrar's Signat

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2008 6:10 A Kenneth Gordon Whitcomb May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Transitions Health Care Sykesville Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex XX M 2□ F 7. Age (In vrs. last birthday) **Funeral** Days 214-22-9883 80 Nov. 1927 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "maryland any Injury or other treasure. 10a. State 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes ANNO Director Baltimore Reisterstown MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 302 Cantata Ct. Apt. 100 Funeral 12. Was Decedent Ever in U.S. Armed Forces? X∑Yes 2 □ Np If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes XX No Specify. Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elmer Fisher Whitcomb Mary Elizabeth Carroll 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BO2 Cantata Ct. Apt. 100 Reisterstown, MD 21136 Loleta C. Whitcomb / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State Lake View Memorial 4 ☐ Donation 5 ☐ Other (Specify) 5/21/08 Sykesville, MD 21. Signature of Fune VService Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Reisterstown Rd. Owings Mills, MD 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carchio vascular Amerosclewno **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence or). Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physiclan/Medical IE FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9□Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 200 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20108 MD 2115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Load Westminister 19 MAHMOOD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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			For State	State of M	arylan			Health and M	lental Hyg	giene	008	1622
			Registrar 1. Decedent's Name (First, Midde	llo I cot)		Ce	rtificate of	Death	2. Date of Dea	Reg. No.	000	10001
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d 21215-0036 Illed within 72 hours after death with the Maryland Hygiene. Hygiene and Tatural' or Items 23a or 28a-1 show the than "matural" or Items 23a or 28a-1 show the than Matural Experience hours hours and the than Matural Experience hours hours and the than Matural Experience hours have hours	L	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Voc Give	?	İ	Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 🎛 No	Hispanic Origin? (Spe ban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Amer Black, White pecify: W	
215-0036 thin 72 hours aft en "natural", or "matural", or		ted	15. Decede	nt's Education		16a. Dece	dent's Usual Occu	pation		16b. Kind	of Business/I	ndustry
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and 2 ealth an 27 is			Leanna Micell	i – daughter				ue, Essex,	MD 21	L221		
Page Page			20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 4 ☐ Donation 5 ☐ Other (Specify)	Met	tro Cre	sition (Name of matory or other pla ematory,	Inc. 5/17	/2008		ion - City or T timore	
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Registrar DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2008 16383

		Por State	Ce	ertificate d	OT I	Death				Reg. No.			
Physician/ Medical Examine	1.	Decedent's Name (First Middle Last)						Date of Dea Month May 8, 20	ath Day D08	Year		of Death 6 hrs	
Carl .	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death									ounty of Dea	ith		
3		Bon Secours Hospital Baltimore											
Funeral	5	. Social Security Number 6. Se	7. Age (In yrs	. last birthday)	_	If Under 1 Year	If Under		8. Date of B	irth(MM/DD/	YYYY) 9. E Fore		State or
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15-0036 filed within 72 hours after death with the Maryland Hygiene. ed other than "natural", or items 23a or 28a-f sho i, the Medical Examiner must be notified at once.		3628 Valley Te	rrace Ant F	15	ı	21:	244			Į	U.S.A	۸.	
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	L	12th grade	na	S	ec	curity					or Ca	ire n	N/H
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Baltimore, MD 212 permit. Pages I and 2 should by Department of Health and Memi Important: If item 27 is mark injury or other traumatic even	12	21. Signature of Funeral Service Licen	see	22 M	2. N	ame and Address	of Facility	+					
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To th within comp			and manner stated.	and/or mives	uya						ate signed		
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IV I	Î	Zabiullah Ali, M.D. Ass	stant Medical Examir		en	n Street, Balt	more, l	MD 212	201				
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature		Angell o							
Registra	ar	MAY 2 (2008 Lener	10 10	A	No. of the last							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 16Caro1 Wilson 2008 2204 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 8. Date of Birth (Month, Day, Year) DEC 8 1939 Birthplace (State or Foreign Country)
 New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1 □ M 2X F Months Days Hours Min 214-38-6956 Director 68 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 TYes 2 XNo Director MD Harford Abingdon 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ?7 Is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be r 3001 St. Clair Drive, Apt. 123 21009 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Douglas 2 Cronk Lucille Van Dusen and 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Blackmon - son 121 Greenwing Court, Murfeesboro, TN Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 5/17/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 05/10 21. Signature of Funeral Service Licensee H. 22. Name and Address of Eacility. Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical yocardia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Physician/Medical the 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed certificate Vital 2 □ No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 patient 1 ☐ Yes completely filled in by the funeral dir 2 ER/Outpatient 3 DOA 0 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 9 within 24 hours a To the Funeral C Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOO Upper Chesapeake Drive, Bel Air, 21014 amora Marco 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year James Arthur Wade 9:26 MAY 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Séasons Hospice at Northwest Hosp. BALTIMOre RANDALLSTOWN 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 03 16 21 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 X M 2 □ F Months Days Hours Min Yrs. 229-14-0003 87 VA Usual Residence of Decedent 10h. County 10c. City. Town or Location 10d. Inside City Limits X☐Yes 2☐No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3925 Fairview Ave 21216 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Truck Drive Steamship Trade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Wade Mary E. Massier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie Mae Wade-Wife 3935 Fairview Ave, Baltimore, Md 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park 5/19/08 Baltimore, Md Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 3a. Part . Enter the disease, or complica ons that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21215 Approximate Interval Between Onset and Death lyme te Cause (Final di e e or condition reting in death) Neumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter or normal cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify)

Physician /Medical **Examiner**

and

physician

has

certificate

this

Hospital or Attending Physician:

death,

within 2

be executed

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "na any Injury or other traumatic event proce.

Physician

/Medical

Examiner

10a State

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Director

Funeral

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Funeral

Director

show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be realised at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner

burial-transi Physician/Medical the attending philosophia signed by the a d be detached for þ Completed page 2: Be 2 After this funeral of Certification: n 24 hours after death, ne Funeral Director: A pletely filled in by the ft.

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

5 Pending

investigation

determined

6 ☐ Could not be

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

23e. Did tobacco use contribute to the cause of death? 2 🗌 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

MAY 15, 2008

		1 ☐ Yes	2 25 No	o 1 □Yes	2 🗆	No
6. Place of Dea	th (C	heck only (one)			
4 Nursing H	ome	5 🗌 Resi	dence	6X Other (Spec	ify)	Hospice

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other

D15872

15 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

30. Name and address of person of death (Item 23a) (Type, Print)

21136

State Registrar

Medical

BOB 25 HArold MAIN 57. 31. Date filed (Month, Day, Year) 32. Registre s Signature 0 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 16, **Physician** 2008 May Waters 8:00 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1007 E. Northern Parkway N/A Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y-05-30-1946 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 □ M 2 🗙 F Director 214-50-1378 61 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Maryland N/A Baltimore 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or Items 23a or Injury or other traumatic event, the Medical Examiner must be r 1007 E. Northern Parkway 21212 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Saltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🗓 No Completed by Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Check Processing Associate |Federal Reserve Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Shirley Booker Ruth Pitts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Waters, Sr. - Husband 1007 E. Northern Parkway Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 05-19-2008 4 ☐ Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Franeral Service License 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Unn Baltimore, Maryland 21214 23a. Part1. Enter the discase, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VARIAN **Physician** 4000 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the burial Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes a No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 14 Natural 5 Pending investigation 1 Tyes 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles Si 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

2 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** AM Betty Jane Wheat 3:00 15 2008 /Medical 4c. County of Death 4b City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner N/A 8. Date of Birth (Month, Day, Year) Dec. 29, 1930 Birthplace (State or Foreign Country) Age (In vrs. last birthday 1 □ M 2 🔀 F 77 Maryland 212-28-7477 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Glen Rock York Pennsylvahia Director 10f. Zip Code 17327 10g. Citizen of What Country? 10e Street and Number USA 3484 Sticks Road Funeral . Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie E. Brown Raymond Harr ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3484 Sticks Road, Glen Rock, Pennsylvania 17327 Charles E. Wheat Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State Metro Crematory 5/19/2008 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Linense ²²Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road, Baltimore, Maryland Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION OSSIBLE Due to (or as a consequence of): CORONARY ARTERY DISCASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2 ☑ No Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PULMONARY EMBOLISM. 2 No 3 Probably 4 Monknown 1 ☐ Yes Completed END STAGE KIDNEY DISCASE 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | 1√10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

be executed and Box 68760. physician the attending nse for P.0. the þ Records, page 2 certificate Division or Vital this After t To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After filled in by the within 24 hours a To the Funeral L

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, th. Me tical Examiner must be notified at

and Mental Hygie

Department of Health ar Important: if Item 27 is any injury or other trau

Physician /Medical

Examiner

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Pages 1

Maryland 21215-0036

Baltimore,

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Medical

State Registrar

DHMH 17 Rev 1/2001

LORRAINE OF ORI -AWUAH, 5607 LUCH RAVEN BLUD, BALTINORE MD 21239 31. Date filed (Month, Day, Year)

fois Awiel no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 2 0 2008

29b. Signature, and title of certifier



29c. License number

D0061789

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 6388 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **JAMES** PETER WIRES 150 3 2005 MA 8 4a. Facility Name (If not institution, give street and number) or Location of Death 4c. County of Death 20115 rupdel MA Sev Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 27,1946 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Hours Min. 212-46-0713 61 Maryland Aug. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Pasadena Maryland Anne Arundel 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8369 Hilda Avenue 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married White 1 □Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of Md. Elementary/Secondary (0-12) College (1-4or 5+) Assistant Manager Radio**i**ogy Hospita1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crownsville VA Cem.

Mildred Mildred

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122

8369 Hilda Avenue, Pasadena, Maryland 21122

05-23-08

Mac Intyre

20c. Location - City or Town, State

Crownsville, Maryland

Physician /Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprired that the performed at once.

Baltimore, Maryland 21215-0036

Physician

/Medical

Director

Funeral

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Completed

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Albert

20a. Method of Disposition

19a. Informant's Name/Relationship (Type. Print)

Leslie M. Wires (Wife)

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service License

30. Name and address of person who co

MAY 2

1 Burial 2 ☐ Cremation 3 ☐ Removal from State

Wires

Examiner

Funeral

Director

Examiner

aftending physician and for use as the burial-trar signed by in 24 hours are:
the Funeral Director: Af

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has

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

23a. Pool 1. Enter the disease, or comp nock, or heart failure. List only of In rediate Cause (Final disease or condition resulting in death)	lications that caused the death. Do not enter the mode of dying, such as cardian ne vause on an line. a	c or respiratory arrest, Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	
that initiated events resulting in death) Last	CDue to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d	23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown
	·	24a. Was an autopsy findings available prior to completion of cause of death? 1 □ ∀es 2 ☑ No 1 □ ∀es 2 ☑ No
25. Was case referred to medical examiner?	26. Place of Dea	ath (Check only one)
12 Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	forme 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one)	sician: To the best of my knowledge, death occurred at the time, date and place ner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	Deputy 29c. License number	29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

within 24 hore To the Fore Completely fi

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CONSTANCE WECKESSER Α. 2003 Mac 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Glerk Boltimore Uba nington Medical Cont r Slen Burnie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex 5. Social Security Number **Funeral** Year, 1 □ M 2 F Days Hours 69 219-26-6697 14, June 1938 Maryland Director Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or : traumatic event, the Medical Examiner must be n U.S.A. 7479 Furnace Branch RoaD Apt. C 21060 death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 1 No Baltimore, Maryland 21215-0036 Specify: Specify: à White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "many Injury or other traumatic exercise. Elementary/Secondary (0-12) College (1-4or 5+) Area Nursing Homes 12 <u>Nurse</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Dorothy Lowman Moor ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Louis B. Weckesser Jr. (Husband) 7479 Furnace Branch Road Apt. C. Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 05-22-08 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Fundral Service Licens Ant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** anoxic KOR DA. /Medical Due to (or as a consequence of): Examiner BUKS Sequentially list conditions, CERTIFICATION APPROVED BY MEDICAL EXAMINES Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed as the burial-trai Due to (or as a consequence of) attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 9□Unknown 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown signed by i 23e. Did tobacco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examine?
1 ✓ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 ☑ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number, or Rural Boute Number, City or Town, State) determined 4 Homicide Furnace Brunch BD Aptc Home 7479 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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301

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington

32. Registrar's Signature

more

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 1110 AM BERNARD LAWRENCE F. WINTER MAY 3008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PERRING PARKWAY MD 2/234 BALTIMORE GENESK TIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 💢 M 2 🗆 F Months Hours 95 214-01-1848 Director AUG. 20,1912 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d Inside City Limits rai", or items 23a or 28a-f show Examiner must be notified at Director BALTIMORE **OVERLEA** 1 ☐ Yes 2√☐ No MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4300 KOLB AVE 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status o filed within 72 hours after de Il Hygiene. other than "natural", or item Black, White, et 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th SUPERVISOR POST OFFICE permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 is marked other i any Injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BERNARD JOHN WINTER WILHELMINA REBECCA MAGLEDT ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET WINTER-WIFE 4300 KOLB AVE BALTIMORE, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dona**jio**n 5 ☐ Other (*Specifiv*) 5/20/08 HOLY REDEEMER BALTIMORE, MD 21. Signatur of Fune al Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. BALTIMORE, MD 21206 6415 BELAIR RD 23a. Dent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ENDSTAGE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as JE FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? for Month Year Day 5 ☐ Other (specify) ed by the a 9 ☐ Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 → Yo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Usursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After 1 28d. Describe how injury occurred 1 Matural 5 Pending Notice in the second within 24 hours after death.

To the Funeral Director: After the function of the function 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certiful 29c. License number P ATTENDING 29d. Date signed (Month, Day, Year) 2008 D067739 111751CIAN MAW NAING OD, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAPARICES NORTH 70 SOLTG 4202 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 2 0 2008

DHMH 17 Rev 1/2001

Registrar

			Please Type or Print in Black Indelible Ink. State of Maryland / Department of H State of Maryland / Department of H Certificate of L	ealth and M	lental Hygi	-	16391
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Ronald Leon Avent		2. Date of Death Month April 3	T	3. Time of Death 2:58 P. M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Washington Adventist Hospital Takoma	Location of Death		4c. County of Dea Montgoi	
3.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	_	thplace (State or Foreign
	Director		229-98-8465	Tiours Will.	December	10,1959	Virginia
	yland		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	8a-fal	ctor	District of Columbia Washington				1XYes 2 No
	with the	Funeral Director	1305 Otis Street, N. E.; Apt. 2	7		g. Citizen of What Co United St a	-
	death me 23	nera	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hi			14. Race - Ame	erican Indian,
21215-0036	72 hours after death with the Maryland natural', or tlame 23a or 28a-f ahow Isal Examilian and the multilan at	by	1 X Never Married 2 Married 1 Yes, specify Cubai 1 Yes, Specify Cubai 1	Specify:			rican erican
15-(- 4	lete	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done a life. DO NOT use retired)	ation Juring most of worki	ing	6b. Kind of Business	/Industry
212	be filed within ital Hygiene. Id other then avent, its may	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Construction	_		orman Con	struction,
	be filed ital Hygid of other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M. Rebecca		
Maryland	is 1 and 2 should be for Health and Mental Hitam 27 is marked of other treumatic aver	7	Charles Wesley Avent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street a				Zip Code)
	alth ar		Cheryl Regina Avent (Sister) 45528 Kilbeggar				
Baltimore,	permit. Pages 1 an Department of Heal Important: if Itam 2 any injury or other once.		20a. Method of Disposition 1 □ Burial 2 ★ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place of Disposition (Name of cemetery), crematory or other place of Disposition (Name of cemetery), crematory or other place of Disposition (Name of cemetery), crematory or other place of Disposition (Name of cemetery), crematory or other place of Disposition (Name of cemetery), crematory or other place of Disposition (Name of cemetery), crematory or other place of Disposition (Name of cemetery), crematory or other place of Disposition (Name of cemetery), crematory or other place of Disposition (Name of cemetery), crematory or other place of Disposition (Name of cemetery), crematory or other place of Disposition (Name of cemetery), crematory or other place of Disposition (Name of	_	9, 2008	Oc. Location - City or	Town, State
altii	permit. P Departm Importar any Inju					cians, In	
8	89 E € 9		Sandaph Difference 600 Kenner	dy Street	, N.W.;W	ashington	,D.C. 20011
			23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) ### Due to (or as a consequence of):	LY VIRUS	(74100		years
***	Examiner		Sequentially list conditions, b.				
	ted nsit	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
ó	be executed sicien and burial-transit	Examin	resulting in death) Last Due to (or as a consequence of):				
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39 ×	leath certificate attending physi I for use as the t	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			224 Patrack da	li
P.O. Box	The law requires that the death certificate ate "as been signed by the attending phy: page 2 shruid be detached for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months? 1			23d. Date of de Month	Day Year
	es that igned by be deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
Vital Records,	w require been sig should b		Chronic Pancheatitis		1 ☐ Yes	s 2 (2/No 3 () P	robably 4 Unknown
ec	as b	Completed	Hepatitis C Renal Insufficia	ency	24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findings available completion of cause of
tal	ien: The l	e Co	25. Was case referred to medical	36 Place of Death		No 1 ☐ Ye	s 2 No
of Vi	ysic is ce direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	or		nce 6 Other (Spe	ecify)
o uc	After Fune		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury Work Work 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Pending (Month, Day Year)	/ at k? Yes 2 □ No	28d. Describe how	w injury occurred	
Division	deat deat ctor: y the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Stree City or Town,	eet and Number or R State)	lural Route Number,
	Hospitu 4 hours Funere tely fille	edical C	29a. Certiflier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time one) 1 Medical Examiner: On the basis of examination and/or investigation, in my open and manner stated.	ne, date and place, pinion, death occurr	and due to the car red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License			d. Date signed (Mon	**
			Vanlen Werland Do	11852	/	4942	2008
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUL A. DEVOCE, MD 4213 GUEEN	SBURG	Pd Hu	attavill	W/2021
2	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	,,,,,,,	24 1.7	, v = / . /)	1 1001

State Registrar 31. Date filed (Month, Day, Year)
MAY 0 7 2008

Amend Item 10b State of Maryland Department 880 earth and Mental Hygiene State Registrar WCHD/SH 5/9/08 per FH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** : 20 FM 2008 larence /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number 200–24–2007 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In vrs. last birthday) **Funeral** May 14, 1931 Pennsylvania 76 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location Harrisburg Daughine Co. 1X Yes 2 □ No Pennsylvania Director Dauphin Co 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? USA 17112 7800 Avondale Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 ☐ No Specify. ģ 3 Widowed 4 Divorced **Black** Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Tire Services Business Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Faust John Bivens ၉ 19a. Informant's Name/Relationship (Type. Print)
Patricia L. Bivens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7800 Avondale Terrace, Harrisburg, (Wife) Pennsylvania 17112 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 7,2008 20c. Location - City or Town, State 1 XBurial 2 Cremation XX Removal from State May Harrisburg, Pennsylvania Blue Ridge Memorial Gardens 4 Donation 5 Other (Specify) 21. Signature o Funeral Se Lochstampfor Funeral Home, Inc. Lochstampfor 48 S. Church Street, Waynesboro, PA 17268 Part 1. Enter the disease, or complications that caused the Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final **Physician** disease or condition resulting in death)) rer whe lmina /Medical Due to (or as a consequence of); **Examiner** inellmonga Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or, or Attending Physician: The law requires that the death certificate be executed bunial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed director, page 2 should be de Division of Vital Records, 4 Unknown 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Inpatient 2 ER/Outpatient 3 🗆 DOA 1 Yes ၉ After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) State 06 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** 11:15 A^M MAY 3,2008 ESTHER B. BEYDA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MONTGOMERY CARRIAGE HILL NURSING HOME BETHESDA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🗓 F Director 99 09/27/1908 **EGYPT** 579-38-4162 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Wedien Examinar must be motified at 1 X Yes 2 □ No Director MARYLAND MONTGOMERY BETHESDA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 5215 WEST CEDAR LANE 20814 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ ÑNo 14. Race - American Indian, Black White etc. 1 and 2 should be filed within 72 hours after thealth and Mental Hygiene. em 27 is marked other than "natural", or ite 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 🔼 No Specify Specify: <u>۾</u> 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ISAAC BIGIO SARAH BEYDA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If fem 27 any injury or other tra once. 6425 DANVILLE COURT, ROCKVILLE, MARYLAND 20852 IRVING A. BEYDA, SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State KING DAVID MEML GDNS 05/05/2008 FALLS CHURCH, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20852 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND Approximate Interval Between Onset and Death Immediate Cause (Final Physician 70 FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PULLOWARY DISEASE CHRONIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been signal page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 **N**O director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🕍 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral c 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury ie Hospital or Attending P. n 24 hours after death. ie Funeral Director: After t 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier i 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated To the I within 2.

State Registrar

29b. Signature and title of certifier



o, MA

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29c. License number

20057124

29d. Date signed (Month, Day, Year)

51510P

			1 - State Registrar	State of Mary		artment of rtificate o		d Mental F	lygien Reg. N	200	8 639
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Ruby P.	Furr		Bolt		2. Date of May		ay 2008 ^e	3. Time of Death 8:00P. M
	Exami		4a. Facility Name (If not institution, give st Shanti Home			Laure]					George's
	Funeral Director		5. Social Security Number 215-20-3426 6. Sex Usual Residence of Decedent		n yrs. last birthday) 93 Yrs.	If Under 1 Yea Months Day		Min. 8. Date of Month, Dec.	31°, 19	14 M	Birthplace (State or Foreign County) aryland
	death with the Maryland ms 23a or 28a-f show Emist Le melified at	ector	Maryland Prince Geo		c. City, Town or Lo Laure1						10d. Inside City Limits 1 Yes 2 No
	ath with t	Funeral Director	7910 Sandy Spring l	Road		10f. Zip Code 2070	7		Ŭn	itizen of What ited S	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exercities must be rediffied at once.	d by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	2. Was Decedent Eve Armed Forces? 1 □Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Ci 1 □Yes 2ሺ\N		? (Specify Yes or uerto Rican, etc.)	No-	14. Race - A Black, W Specify:	merican Indian, hite, etc. White
Maryland 21215-0036	I within 72 ho giene. r than "natu r e Modeal	Completed by	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use reti Cechnici	ne during most of ired)	working	Ī	Kind of Busine	Maryland
yland	2 should be filed and Mental Hyg is marked othe raumatic event,	To Be C	17. Father's Name (First, Middle, Last) Walter Doyle			_		Name (First, Mid Benton	dle, Maide	n Surname)	
	1 and 2 sho Health and em 27 is ma		19a. Informant's Name/Relationship (Type Mary Siye -daughter	e. Print)	19b. Mailir 817 N	ng Address (Stre Nontgome	et and Number o	et Laure	nber, City l , Ma	or Town, Stat ryland	e, Zip <u>C</u> ode) 20707
Baltimore,	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition 1	mount from State		natory`or other p		Date netery 5/8,		-	or Town, State le, Maryland
Balt	permit. Depart Import any Inj		21. Signature of Funeral Service Licenses	neward				rdt Fune Road Be			A arvland 20705
	Physician /Medical Examiner	iner	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	cause on each line.	y Artery			rdiac or respirator	y arrest,		Approximate Interval Between Onset and Death Years
8760,	icate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):						
P.O. Box 6	the death certifications the attending I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	☐Ectopic pregna ☐Other (specify)			-	23d. Date of Month	delivery Day Year
rds, P	equires that en signed t	ed by Pl	Part II. Other significant conditions control Dementia; Hypothyro	_	ot resulting in the u	nderlying cause	given in Part I.				e to the cause of death? Probably 4 🌠 Unknown
I Reco	The law recate has be page 2 sho	Completed by						24a. W au pr 1 □ Ye	utopsy erformed?	death	autopsy findings available to completion of cause of n? Yes 2 XNo
f Vita	ysician: is certific director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	spital: 1 ☐ Inpatient	2 ☐ ER/Outpatier	nt 3 DOA	241	Death (Check on		6 ¥ TOther /5	SpecifyGroup home
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filler in by the fineral director, page 2 should be detached for use as	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day, Ye 28e. Place of Injury building, etc. (3	28b. Time of Injury	28c. Ir W M 1	njury at /ork? □Yes 2□No	28d. Descri	be how inj	ury occurred	r Rural Route Number,
	ne Hospita n 24 hours ne Funeral	Medical C	29a. Certifier 1 Certifying Physic (Check only one)		amination and/or in						
	*	Me	29b. Signature and title of certifier	rap ni	>	29c. Lice D23	ense number 181		29d. D	May 5	onth, Day, Year) , 2008
	10		30. Name and address of person who com Rajkumar Bhojraj, N	1.D. 5632	Annapolis	Print) Road,#	10 Blade	ensburg,	Mary	land 20	0710
	Sta	ite	31. Date filed (Month, Day, Year)	32 legistrar's	Signature	cuti I			-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** 2. 12:29 A M MAY 2008 BRENNER /Medical SYDELLE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY **BETHESDA** SUBURBAN HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 □ M 2X□ F 87 Yrs 089-16-5264 NEW YORK Director AUG 25, 1920 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 11X Yes 2□ No Director MONTGOMERY SILVER SPRING MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3310 NORTH LEISURE WORLD BLVD #824 20906 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 Tho If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🙀 No WHITE Specify: 2 3 □XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TEACHER/COUNSELOR D.C. PUBLIC SCHOOLS d 2 should be filed with and Mental Hygies 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MILTON EDELSTEIN MARY COHEN traumatic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is,
any injury or other traus 20817 8121 THOREAU DRIVE, BETHESDA, MARYLAND MARJORIE ANN BOHI, DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING DAVID MEML GDNS:05/05/2008 FALLS CHURCH, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. EDWARD SAGEL FUNERAL DIRECTI 1091 ROCKVILLE PIKE, ROCKVIL 23a. Part1. Enter the discussion of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. 20852 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY ARREST /Medical 45 MIN Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) executed PNEUMOTHORAX Due to (or as a consequence of): requires that the death certificate be 30 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □ Yes 2X No **a**g 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 45 ☐ Unknown mipleted 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 XNo 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1**⊡X**Yes 2 ☐ No 1 ☐ Inpatient 2 A ER/Outpatient 3 ☐ DOA in 24 hours after death.

The Funeral Director: After this pletely illied in by the funeral of the BRETINER Edical Certification: The Edical Certification: The Edical Certification: The Edical Certification: The Edical Certification: The Edical Certification: The Edical Certification in The Edical Certificati 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 To the Q 29d. Date signed (Month, Day, Year) 29b. Signature and fitter of certifier

Baltimore, Maryland 21215-0036

Box 68760.

o.

<u>Ч</u>

Records,

Division of Vital

State Registrar 31. Date filed (Month, Day, Year) MAY 0 6 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

•		1- For State Certificate Registrar	of Death	Reg. N	_{10.} 2008 16390
Physicia	an/	Decedent's Name (First, Middle,Last)		Date of Death Month Da	3. Time of Death
Medical Exami	ner	Carolyn Lee Baker 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	May 12, 2008	y Year 2305 hrs 4c. County of Death
En Norma		11 West Baltimore Street # 111	Hagerstown		Washington
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If Under 1 Year If Under 24Hrs Months Days Hours Min	8. Date of Birth (M	M/DD/YYYY) 9. Birthplace (State or Foreign Maryland 600 Maryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
*		Maryland Washington Hagers			1 Y Yes 2 No
12 140 with the Marylan as 23a or 28a-f st	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
2 140		11 West Baltimore Street	21740	(U.S.A.
th with	Funera		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at once		1 Yes 2 X No	Yes 2 X No specify:		Specify: White
ours af atural camin	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	dent's Usual Occupation (Give kind of	work done 16t	o. Kind of Business/Industry
	olete	College (1-4 or 5+)	g most of working life. DO NOT use ret Nemaker	irea)	0
-003 J withingrene.	mo	9 HOr 17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	Own Home
21215-0036 Uld be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medikal Examiner.	Be	Raymond Leroy Ruck	Doroth		
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medica	٩		ling Address (Street and Number or		, City or Town, State, Zip Code)
		Christina L. Baker Daughter 137: 20a. Method of Disposition 20b. Place of Disp	19 National Pike,	Clear Spr	ring, Maryland 21722
F 8 4 F 2		1 X Burial 2 Cremation 3 Removal from State crematory or Mt. Olivet	other place) Mennonite Cem. 05	5-16-08 Ma	ugansville, Marvland
Baltimo permit. Page Department or Importants injury or oth	H	4 Donation 5 Other Specify:	Name and Address of Facility Office Coffman	and the second	
ii ji Deg ထ		10. noel grady	J East Antietam St	creet, Haq	erstown, Md. 21/40 j
Physician /Medical	2 - 23	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	er the mode of dying, such as cardiac o	or respiratory arrest,	Between Onset and
⊂xaminer		Immediate Cause (Final disease or condition resulting in death) a. Provinte intoxication intoxi	on		Death
		Sequentially list conditions, b			
	ine	if any, leading to immediate Due to (or as a consequence of):			
ed sait	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
760, icate be executed physician and the burial - transit	I	d. X UNPENDED AMENDED			
760, icate be physiciate the buria	Medical	23a_27_28a_f_roerMF_cq88	30 6/20/08 TT		23d. Date of delivery
ox 687 eath certific attending p		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death	Fetal death 3 Ectopic pregn.	ancy	Month Day Year
Box 68 e death certif	Physician	1 Yes 2 No 9 V Unknown 9 Unknown	Other (Specify)		
hat the	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		co use contribute to the cause of death?
ords, P	ted t			1 Yes 2	Probably 4 ✓ Unknown 24b. Were autopsy findings available
COFC law re has be	Completed			autopsy	prior to completion of cause of
tal Rec		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2	No 1 ✓ Yes 2 No
Vita ysician ysician directo	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	Other		idence 6 🗸 Other: Scene
ion of tending Pheath.	-1	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time		28d. Describe how	injury occurred
	Satic	2 Accident Investigation Fnd 5/12/2008 Fnd 11:		unk	
Division of Vital Records, pital or Attending Physician: The law requirent after death.	Certification:	3 Suicide 6 XCould not be determined (Specify) for mode vocal decorptions		or Town, State	et and Number or Rural Route Number, City Hagerstown, MD
Hospi 24 hou Funer tely fill		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death or	curred at the time, date and place, and	due to the cause(s)	and manner as stated.
Div To the Hospital or within 24 hours afte To the Funeral Dis	edical	one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.	gation, in my opinion, death occurred	at the time, date and	place, and due to the cause(s)
1222	Σ	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (item 23a)	O.C.M.E.		lay 13, 2008
	-		eet, Baltimore, MD 21201		
Sta	ate	31. Date filed (Mooth, Day, Year) 2008 32. Registrar's Signature	ant s		
Regist			un -	- Anna	-
The second second second	ALC: U	ORICH	V7-12	OUIVIE	

			For State Registrar		State	of Marylar		artment of F rtificate of	lealth and M <i>Death</i>		giene Reg. No. 2	08	16397
	Physicia	an	Decedent's Nam							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (Y ANN CL		umber)		4b. City, Town, o	r Location of Death	MAY	4, 200		7:18 P ^M
		A	HOSPICE					CENTRI			QUEE	N ANI	NE'S
	Funeral Director		5. Social Security 1 213–42–0	300	. Sex 1 □ M 2 🗶 F	7. Age (In yrs. 65		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat APRIL 2	9,1943	9. Birthpl Coun MAR	lace (State or Foreign try) YI.AND
	yland I ow at		Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or Lo	ocation				1	0d. Inside City Limits
	e Mar	ctor	MARYLAND	QUEEN	ANNE'S		CENTR	EVILLE					¹ X Yes 2□No
	with th	Director	10e. Street and Nu		DDACE			10f. Zip Code 21617			10g. Citizen of W		
	ms 23	Funeral	11. Marital Status	GHMAN TE	12. Was De	cedent Ever in U	I.S. 13.		lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No	UNITED 14. Race		an Indian,
	s 1 and 2 should be flied within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene, and The The The The The The The The The The	by	1 ☐ Never Mar 3 ☐ Widowed	rried 2 Married	Armed F 1 ☐ Yes If Yes, G Year or	2 ▼ No		1 ☐ Yes 2X No	an, Mexican, Puerto Specify:	Rican, etc.)		white, wh	
	"natur	Completed	(Spe	15. Decedent's ecify only highest	Education grade completed)	16a. Dece	dent's Usual Occup	oation during most of worki d)	ing	16b. Kind of Bu	siness/Inc	dustry
7	filed within Hygiene. rther than " ent, the Me	ошр	Elementary/Second 11	ondary (0-12)	College	(1-4or 5+)	1	MAKER/WA			RESTAUR	ANT	
2	be filectal Hyg	BeC	17. Father's Name		*				18. Mother's Name			9)	
2	should be nd Mental marked o	우	19a. Informant's N	LL GRIME			106 84511	Add (Ot	L	GROLLM			
=	1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ther traumatic event, the M		BONNIE C						and Number or Rura RCLAY, MAR			State, Zip	Code)
,	Pages 1 a nent of Hea nt; If Item iry or othe			sposition Cremation 3 5 Other (Spe		n State	Place of Dispo cemetery, cre	osition (Name of matory or other place	; [Date	20c. Location - 0	•	•
	permit. Pages Department of Important: If I: any Injury or once.		21. Signature of F			hen:	FF 40	2 Name and Addre LLOWS, HE	LFENBEIN &	S NEWNA	M FUNERA	L HO	ME P.A.
ñ		-	23a. Part1. Enter shock, or he	the disease, or co	mplications that	caused the dear			ng, such as cardiac			200911	Approximate Interval Between
F	Physician /Medical		Immediate Cause disease or condition resulting in death)	on	a	LT FAILU		THRIVE				1	Onset and Death MONTHS
ı	Examiner			-		o (or as a consec ONIC UNR		NC PATN				1	MONTHS
	ed sit	iner	Sequentially list contains to in cause. Enter Und Cause (Disease or that initiated event	onditions, influediate lerlying	Due to	(or as a consec	quence of):	NO TILL					
	ficate be executed physician and s the burial-transit	Examine	that initiated event resulting in death)	ts Last	0.	ONIC GAS							MONTHS
	ite be o	edical I		•	d		·						
	sertifica ding ph	/Med	IF FEMALE:		220 If you	utoome of avega					1		
3	The law requires that the death certifite has been signed by the attending to age 2 should be detached for use as	Physician/M	23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	2 months? No	1 ☐Live	utcome pf pregn birth 2 □ Feta gnant at time of o nown	aldeath 3	Ectopic pregnanc Other (specify)	у		23d. Date Mor	e of delive nth	ery Day Year
	res that the signed by be detact	by Ph	Part II. Other sign	ificant conditions		death but not res	sulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	obacco use contr	ibute to th	ne cause of death?
Ś	w require been sig should be			TOID ART	HRITIS					10	∕es 2. No	3□ Prob	ably 4 □Unknown
	The law rate has be	Completed	DEPRES	SSION						24a. Was autop perfo 1□ Yes	nsy p rm o d? d	Vere auto nor to cor eath? Yes	psy findings available npletion of cause of
	sician: The last certificate ha lirector, page 2	Be	25. Was case refe examiner?		Hoopital:			l ou	26. Place of Death	Check only o	ne) H	OSPIC	CE HOUSE
5	Phys r this eral dir	- To	1 ☐ Yes 2X 27. Manner of Dea			Inpatient 2	ER/Outpatier 28b. Time o		4 LI Nursing Ho		dence 6 Othe		/)
	ath. or; After	atior	1 X Natural 2 ☐ Accident	5 ☐ Pending investigat	ion	nth, Day Year)	Injury	if 28c. Injui Wor M 1 □	rk? Yes 2 □ No		ion injury occurs	Ju	
	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certifice tely filled in by the funeral director, p	Certification	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	20e. Flac	e of injury - At h ding, etc. (Speci	ome, farm, str	reet, factory, office		28f. Location (8 City or Tov	Street and Number vn, State)	er or Rura	I Route Number,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director; Aft completely filled in by the fun	Medical (29a. Certifier (Check only one)	1 X Certifying 2 ☐ Medical Ex	aminer: On the	ne best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred at the ti	me, date and place, opinion, death occurr	and due to the red at the time,	cause(s) and ma date and place, a	nner as st	tated. the cause(s)
i	withii	Me	29b. Signature and	d title of certifier	11/1	X		29c. Licens	se number	72	29d. Date signed		
	5,05		30. Name and address of person who completed cardse of death (Item 23a) (Type, Print)										18
	1,		MICHAEL 1	D. CROWL	EY.M.D.	610 DUT	CHMAN '	S LANE. EA	ASTON, MD 2	21601			
	Sta Registra		31. Date filed (Mor	MAY YOU'7	2008 32.	egistrar's Sign	ature A	berte			·		

			1 - For State Registrar	State of	Marylan		artment of F rtificate of		d Menta		ene 2	008	163	98
a .	Physici		Decedent's Name (First, Middle MICHAEL BRADLE						2. Date Mor		Day 2	Year 008	3. Time of De. 0419	ath M
	/Medic Examin		4a. Facility Name (If not institution MEMORIAL HOSP.		nber)							c. County of Death TALBOT		
	Funeral Director		5. Social Security Number 482–28–3630		7. Age (In yrs. I	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 H	lin. (Mo	of Birth nth, Day, Y	'ear)	9. Birth	nplace (State or Fo untry) NECTICUT	
	Maryland f show led at	or	Usual Residence of Decedent 10a. State 10b. County MD TA	LBOT		, Town or Lo							10d. Inside City L	
	an or 28a- st be notif	Il Director	10e. Street and Number 700 PORT STRE	ET, UNIT 1	10		10f. Zip Code	2160)1	100	ı. Citizen o	of What Co	•	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. then "natural", or Items 23a or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	Armed For			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 (X)No	lispanic Origin? an, Mexican, Pu Specify:	? (Specify Yes uerto Rican, e	s or No- etc.)		lack, White	rican Indian, e, etc. WHITE	
Maryland 21215-0036	d within 72 ho giene. er than "natur , the Medical.	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed) College (1	-4or 5+)	(Give life. I	dent's Usual Occup kind of work done DO NOT use retired PRESIDEN	during most of d)				Business/I		
yland	should be filed ind Mental Hygi marked other umatic event, ti	To Be (17. Father's Name (First, Middle, WILLIAM F. CA	•		,		18. Mother's I	Name (First,			,		
Itimore, Mary	9 0 -		19a. Informant's Name/Relations N . KATHERINE KI 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	DDY CASEY/	20b. P	700 I	ng Address (Street PORT STRE sition (Name of matory or other place EMETERY	ET, UNI		EAS'	ron,	MD 21		
Balt	permit. Pag Department Important: I any Injury o		21. Signature Fund of Service	1. offer	Ku	FI 40	2. Name and Addre ELLOWS, HE D8 S. LIB	LFENBEI ERTY_SI	C., CEN	TREV	ILLE,	RAL H MD 2	OME, P.A	١.
8760,	Physician /Medical Examiner physician and physician physician with physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury tain initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											Approximate Interval Betwee Onset and Dea	en atth
.O. Box 6	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as to	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live b	come pf pregna irth 2 Fetal ant at time of de own	Ideath 3	Ectopic pregnanc			23d. Date of delivery Month Day		•	ar	
Д.	w requires that been signed by should be deta	þ	Part II. Other significant conditi	ons contributing to de	eath but not resu	ulting in the u	nderlying cause giv	ren in Part I.	230	e. Did toba	id tobacco use contribute to the cause of death? ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown			
Vital Records,		Completed							1_		d? No	b. Were au prior to death? 1 ☐ Yes	topsy findings ava completion of caus 2 ☐ No	ailable se of
Division or Vit	iling Phy After this funeral d	ation: To Be	25. Was case referred to medica examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	Hospital: 1 1 28a. Date of (Mont	npatient 2 Dof Injury	ER/Outpatier 28b. Time o Injury	f 28c. Inju	er: 4 ☐ Nursin	Death (Checking Home 5 [28d. De		ce 6 □0		cify)	
DIVIS	spital or Attencours after death neral Director: filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ained 200, Flace	of injury - At hong, etc. (Specify	me, farm, str	eet, factory, office		28f. Loc City	ation (Stre or Town,	et and Nu State)	mber or Ru	ural Route Numbe	r,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	ledical	(Check only 5 ☐ Medical one)	ng Physician: To the Examiner: On the ba and manr	asis of examinat	wledge, death tion and/or in	h occurred at the ti vestigation, in my	me, date and popinion, death of	place, and due occurred at th	e time, da	te and plac	ce, and due	e to the cause(s)	
)	To the within To the complex	Σ	29b. Signature and title of certifie	Hon	m		D 4	5988	7	296	516		h, Day, Year)	
	1040		30. Name and address of person DAVID H. SMIT	н м.р. 822	21 TEAL	DRIVE	•	302, EAS	STON,	MD 21	601			
9	Sta Registr		31. Date filed (Month, Day, Year)		egistrar's Signa		nede							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2008 May 6:45 A Jean Carpenter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 13436 Resh Rd. Hagerstown 1 Year | If Under 24 Hrs Washington 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, State or Foreign Birthplace Country) **Funeral** 1 □ M XXF Months Days Hours 214-34-9342 71 Dec. 1,1936 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show idical Examiner must be notified at 10b. County 1 ☐ Yes 2 X No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13436 Resh Rd. 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany Injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Milford George Anderson Ruth Anna Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Penny Clark - Daughter 1004 West Irvin Ave. Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Bunal 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory May 2,2008 Smithsburg, Maryland 4 ☐ Donation 5 Other (Spe 21. Signature of Funeral Septos OSBOTTE TUTEL AT INTERPRETATION HOME, P.A. 425 S. Conococheague St. Williamsport, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stroke days /Medical Due to (or as a consequence of) Examiner hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1☐ Yes 2☐ No 4□Pregnant et time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 28e. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) (Check only

that the death certificate be executed Division or Vital Records, P.O. Box 68760, ospital or Attending Physician: hours after death.

uneral Director: After this certifica

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1138 Opal MD Ct. Hagerstown, MD 31. Date filed (Month Agy 32. Resistrar's Signature 0 2

29b. Signature and title of certifier

State Registrar

29c. License number

058195

21740

29d. Date signed (Month, Day, Year) 05/01/2008

			For State Registrar		State	of Marylar		artment of l rtificate of				giene Reg. No.	008	16400	
	Dhyaisi		1. Decedent's Name	(First, Middle,	Last)						2. Date of De Month		Year_	3. Time of Death	
	Physici /Medi		Ca	therir	ne Car	ter					May	2,	2008	5:10 A ^M	
	Examir	ner	4a. Facility Name (If					4b. City, Town,				4c. Co	ounty of Death		
- Ç			Future 5. Social Security Nu		Pinevi 6. Sex	Page (In yrs	last hirthday	C1 If Under 1 Year	into If Unde		8. Date of Bir	P.G.		Jana (Ctata as Fassins	
	Funeral Director		241-34-		1 M 2 X F	88	Yrs.	Months Days		Min.	(Month, Da 10-19	y, Year)	S.C	lace (State or Foreign atry)	
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	the M 28a-f lotifie	Director	10e. Street and Num				1016 .	10f. Zip Code				10- Citizon	n of What Cour	*****	
	3a or		304 Gei		Court			207	44			-	U.S.A.		
	death ms 2: r mus	Funeral	11. Marital Status		12. Was Dec	edent Ever in L	J.S. 13.	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					Race - Americ		
9	after or ite mine		1 ☐ Never Marrie	ed 2 Marrie	Armed F d 1 ☐ Yes If Yes, G	3F No	it Yes, specify Cul 1 □ Yes 25x No			Rican, etc.)		Black, White, pecify: Bl a	_		
9	12 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 1 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	d by	3 Widowed ∠		Year or I										
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212		E O	Elementary/Secon	dary (0-12)	College	(1-4or 5+)		ındry W		r		Pr	ivate		
שָׁל		BeC	17. Father's Name (F	First, Middle, L	ast)				18. Moth	er's Name	(First, Middle,	Maiden Su	rname)		
ylaı		To	Joh	n Duke	es		_				ie McC				
Maryland 21215-0036	Cl 00		19a. Informant's Nar				I	ng Address <i>(Stree</i> Gemini							
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Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 2 any Injury or other		21. Signature			1	/ 22	Name and Addr Hacket 814 Up	ess of Faci	uņe	ral Ch	apel	, Inc.	- 46 - 46 -	
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.O. Box 6	the death certifi y the attending iched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown		1 ☐Live	utcome pf pregn birth 2 Fet nant at time of nown	al death 3 □	Ectopic pregnand Other (specify)	су			230	l. Date of delive	ery Day Year	
or Vital Records, P.	law requires that the d as been signed by the 2 should be detached	Completed by PI	Part II. Other signification	cant condition	me 1/1	leath but not res	sulting in the u	nderlying cause gi	ven in Part	l.				ne cause of death?	
000	@ 61 C/	plete	Perion	ICRA	125	cula	4 70	sezs	e		24a. Was		24b. Were auto	psy findings available	
Ä	The ate h	E	Covo	n 3 + ~	O. TC			C.p			autor perfo 1⊟ Yes	rmed?	death?	mpletion of cause of 2 ☐ No	
/ita	iclan: Th certificate ector, pag	Be (25. Was case referre			/			26. Plac	e of Death	(Check only o				
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Division	Attending r death. ector: After by the fune	ficat	2 ☐ Accident 3 ☐ Suicide	6 Could no	t be 28e. Plac	e of injury - At h	ome, farm, str	eet, factory, office			28f. Location (5	Street and N	lumber or Rura	I Route Number	
ă	al or safter	Certification:	4 Homicide	determin	build	ding, etc. (Speci	fy)				City or Tov	vn, State)		,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)	Certifying	Physician: To th xaminer: On the l and mar	e best of my kno basis of examination	owledge, death ation and/or In	n occurred at the t vestigation, in my	ime, date a opinion, de	nd place, ath occurr	and due to the red at the time,	cause(s) an date and pl	d manner as s ace, and due to	tated. the cause(s)	
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-)		30. Name and addres	ss of person w	ho completed cau			Print) hern A	ve. S	5.E.			20032		
5	Sta Registr		31. Date filed (Month	, Day, Year)	63	Registrar's Sign		we							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** May 4, 2008 7:25 A M Adele Clar /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hebrew Home of Greater Washington Rockville Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 2 😾 F 1917 Maryland July 24, 90 Director 005-18-3037 Usual Residence of Decedent 10d. inside City Limits 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f show must be notified at 1X Yes 2 □ No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant If item 27 is marked other than "natural", or items 23a or : any or other traumatic event, the Medical Examiner must be any or other traumatic event, the Medical Examiner. 6121 Montrose Road 20852 U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify by Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Belle Adler 2 Samuel Greenberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. 15210 Springfield Road Phyllis A. Haltermann - Dgt. Darnestown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gardens 5/6/2008 21. Signature of Funeral Service Licensee Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pulmonary Obstructive Immediate Cause (Final Chronic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 📉 No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 INo perform 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred injury 1 X Natural 5 Pending investigation 1 Tyes 2 🗌 No nours after death. neral Director: A death. 2 Accident 6 Could not be determined

Division or Vital Records, P.O. Box 68760

within 24 hours a To the Funeral D

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

06

DHMH 17 Rev 1/2001

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1) 0036716

6121 Montrose Kt. Nockeille Md 20852

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

Kundrat, Mill

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Registrar

State

Stuart Turkewitz, MD

31. Date filed (Month, Day, Year)

MAY 0 7 2008

32. Registrar's Signature

7500 Greenway Center Drive #403 Greenbelt, MD 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2008 11:30 A^M May /Medical Katherine Virginia Conneely 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline 26327 Hobbs Road If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 92 Director February 15, 1916 | Maryland 056-01-4295 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at 1 ☐ Yes 2 😿 No Director Caroline Denton Maryland 10e. Street and Number 10f. Zip Code 10n. Citizen of What Country? 26327 Hobbs Road 21629 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Caucasian þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Clothing Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Manufacturing Jith and Mental Hw 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked any injury or other traumatic ew Christina Labbes ပ <u>Sparwasser</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas J.M. Conneely, Sr. son 26327 Hobbs Road, Denton, Maryland 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Denton Cemetery 5/4/2008 Denton, Maryland 21. Signature of Funeral Service Lipense Moore Funeral Home, P.A. Denton, Maryland 22. Name and Address of Facility sucophy 1/1/och 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21629 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DISTASE ARTERY CORONARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was ... autopsy performed? Yes 25 (No has page 2 certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence (Mother (Specify) 2 No 1 ☐ Yes 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Watural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investination in my opinion, death account of the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Records, P.O. Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Medical State Registrar

MAY 05 2008 DHMH 17 Rev 1/2001

Korah Pulimood, M.D.,

he and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title

31. Date filed (Month, Day, Year)

32. Registrar's Signature **ORIGINAL**

D0053815

912 Market Street, Denton, Maryland

29d. Date signed (Month, Day, Year)

2008

21629

PB 3

1	-	For State Registrar
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Reg. No.	U	U	L

			1 - State Registrar			Cei	rtificate of	Death			Reg. No	2008	3 6401
6	Physici	an	1. Decedent's Name (First, Middle, La						2	2. Date of De	eath Da	v Year	3. Time of Death
	/Medic		Philip A	nthony D'	Agosti	no				May 4		008	11:15 A ^M
	Examin	er	4a. Facility Name (If not institution, gi	,			4b. City, Town, o				40	. County of Dea	ath
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	Funeral Director		, ,	Sex 7. Age	(In yrs. last	Vrs.	Months Days	Hours	Min.	3. Date of Bi (Month, Da Aug • 2	av. Year.	9. BII	rthplace (State or Foreign ountry) ush. D.C.
3	and it		10a. State 10b. County		10c. City, To	own or Lo	cation						10d. Inside City Limits
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4	r 28a notif	Director	10e. Street and Number				10f. Zip Code				10g. Ci	tizen of What C	ountry?
3	23a o st be	a D	55 Terrace Driv	e			200	378				US	SA
1	ems dean	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. \	Was Decedent of H	lispanic Ori	igin? (Spec	ify Yes or No	0-	14. Race - Am Black, Whi	
0000	ral", or Ita	þ	1 □ Never Married 2 □ Married 3XX] Widowed 4 □ Divorced	1 □Yes 2□N If Yes, Give 🔨 Year or Dates:	0		1 □ Yes 2 🕱 No					Specify:	White
ה ה	"natu dical	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	10	Ba. Deced (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during mos	at of working	7	16b. K	(ind of Business	s/Industry
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Š	permit. Fages I and Z should be filed within 7 z hours after death with the Maryland Important. If them 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	은	Antonio 19a. Informant's Name/Relationship	(Time Print)		gost.	100 ng Address (Street		ilomer		nor City		enticore
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ָּע ע		-	20a. Method of Disposition	OSTITIO (SOI	20b. Place	of Dispo	sition (Name of	i	Da	te	-	ocation - City o	
			1 ☑ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci				natorý or other plac Cemetery		May 7	7		_	
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	100		23a. Part1. Enter the disease, or con shock, or heart failure. List only		the death. D						-	OWINGS	Approximate
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	/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence	e of):	neer						
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		Jer	Sequentially list conditions, If any leading to in include cause. Enter Underlying Cause (Disease or injury	Due to for as a	contentiveno	e ofic	10.01.0						
4	cure.	Examiner	that initiated events	C									
,	ian al		resulting in death) Last	Due to (or as a	consequent	e of):							
200	hysic the bi	Medical		_ d									
Ď	ling p	Mec	IF FEMALE:								- 1		
	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Aho 9 Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	☐ Fetal dea]Ectopic pregnanc]Other <i>(specify)</i> _	/				23d. Date of de Month	elivery Day Year
, the	ed by detai		Part II. Other significant conditions	contributing to death bu	t not resulting	in the ur	nderlying cause giv	en in Part I.		23e. Did	tobacco	use contribute t	to the cause of death?
	n sign	d by	Urinay fra	ct infe	cha					1 🗆	Yes 2	!□No 3□F	robably 4 Onknown
5	shou	Completed	Comma	Tale 2						24a. Was	an	24h Were a	utopsy findings available
ב ב	e has	шc		any !	1					auto perf	psy ormed?	I death?	utopsy findings available completion of cause of
ָבֵּי ד <u>ַ</u>	tificat		25. Was case referred to medical					26 Place	of Death (1□ Yes Check only		o 1∐Ye	s 2□No
> 15	is cer direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatier	nt 2 ☐ ER/	 Outpatien	t 3 DOA Oth	or:				6 □Other (Spe	ecify)
5 6	eral leral		27. Manner of Death	28a. Date of Injury (Month, Day	/ 281	o. Time of Injury				d. Describe			Sury
5 5	ath. Te fur	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	, , ,	/ cui/	injury		Yes 2□	No				
	recto	tific	3 Suicide 6 Could not be determined		y - At home, (Specify)	farm, stre	eet, factory, office		28	f. Location (Street a	nd Number or F	Rural Route Number,
2 5	rs aft	Cer							10				
Hoen	24 hou	Medical	29a. Certifier 1 ☐ Certifying P. (Check only 2 ☐ Medical Exa	nysician: To the best o miner: On the basis of and manner stat	examination	lge, death and/or in	n occurred at the ti- vestigation, in my o	me, date an opinion, dea	nd place, ar ath occurre	nd due to the d at the time	cause(s , date an	s) and manner and du	s stated. le to the cause(s)
, \$	o the	Me	29b. Signature and title of certifier	, and marrier oftan			29c. Licens	e number			29d. Da	ate signed (Mon	th, Day, Year)
· ·	->-0		1 ho	2001			73	375	88			5/5/0	
	\		30. Name and address of person who	completed cause of de	ath (Item 23)	a) (Type	Print)					, - /	
RU	10		Rafik Nasr, MD.	005 77			rive, Sui	ite 2,	, Lust	oy, MD	206	557	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra		K	Corell 1	,					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For Amend Item Registrar	n 23a per dr	• ,88 7	9,05%	0/08dhb rificate of	Death	and M	entai ny	ygıe Reg.	No.20(18	16405	
п	Physici	an	1. Decedent's Name (First, Midd	lle, Last)						2. Date of D Month		Day `	Year	3. Time of Death	
	/Medi		Morris Deutsch						1					4:10 A M	
	Examir		4a. Facility Name (If not institution	on, give street and number)		4b. City, Town, or Location of Death					4c. County of Death			
-			Montgomery Gene	eral Hospita	1		01ney				Montgomery			y	
	Funeral		5. Social Security Number	6. Sex 7. A 1⊠ M 2□ F	ge (In yrs.	last birthday)	If Under 1 Year Months Days	If Unde	er 24 Hrs. Min.	8. Date of Bi (Month, D	irth Dav. Ye	ar)	9. Birthp	lace (State or Foreign try)	
	Director		076-12-0606	IMAM ZLIF	88	Yrs.	Incharis Bayo	Tiours]	May 15	, 1	919 N		l'órk_	
	pur 💉		Usual Residence of Decedent 10a. State 10b. County		100 Cit	y, Town or Lo	antion				10d Inside Ch. Limite				
	aryla Shor	<u>_</u>	Toa. State Tob. County		100, 01	y, lown or Lo	cation						0d. Inside City Limits		
	8a-f	Sc	Maryland Montg	gomery	Si	lver S								1 ☑Yes 2 ☐ No	
	∯ • or 2	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?			try?	
	ath w	<u>a</u>	3701 Internation	onal Drive #	531		20906					S.A.			
	r deg	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	S. 13.	Was Decedent of H	Decedent of Hispanic Origin? (Specify Yes or Ns, specify Cuban, Mexican, Puerto Rican, etc.)			0-	14. Race	- America White, e		
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examirae must be notified at		1 Never Married 2 Mai	If Yes Give	No	1	1 ☐ Yes 2 🖾 No Specify:			,,	Consitu				
Ö	ural"	d b	3 Widowed 4 Divorced	Year or Dates:	les:			,.			Specify:	Whi	te		
21215-0036	72 h "natu	Completed by	15. Deceder (Specify only highe	nt's Education est grade completed)	College (1-4or 5+) (Give life. E		dent's Usual Occup kind of work done	durina mo	st of working	g	16b. Kind		iness/Ind	lustry	
121	/ithin ine. han	E E	Elementary/Secondary (0-12)	College (1-4or			DO NOT use retire	d)							
2	led w tygie her t	ပိ		1 2		Accou	ntant	T			_	counti			
5	ould be fill Mental H arked ott atic even	å	17. Father's Name (First, Middle,	. Last)				18. Moth	her's Name	(First, Middle	e, Maio	den Surname))		
ž		မ	Samuel Deutsch						Kulev:						
<u>a</u>	2 sh n and is m raum	de	19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailir	ng Address (Street	and Numi	ber or Rural	Route Numi	ber, Ci	ty or Town, S	tate, Zip	Code)	
~	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventinat must be notified at once.		Helen H. Deutso	h - Wife										MD 20906	
9			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 M Bamaval from State	20b. F	Place of Dispo emetery, cren	sition (Name of natory or other plac	ce)	Da	ate	20c	. Location - C	ity or To	wn, State	
Ξ	Pag ment ant: ury o		4 Donation 5 DOther (5	Specify)	Kin	g Davi	d Mem. Go	dns.	5/4/	2008	Fa	alls Ch	nurch	n, Virginia	
Baltimore, Maryland	permit. Depart Import any inj		21. Signature of Funeral Service			Ed	Name and Addre	ess of Faci el Fu	lity ineral	Direc	ctio	on, Inc	2.		
		Tonald . Stattlemys 1091 Rockville Pike Rockville, MD 20852													
		2 -01		r complications that cause t only one cause on each I	d the death	n. Do not ent	er the mode of dyli	ng, such a	is cardiac or	respiratory	arrest,			Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	Co	MPI	ETE	HEI	ART	B	LOCK	<			Oriset and Death	
and the same	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):	HE,		1			. ~			
	Lxammer	_	Sequentially list conditions.	b. ACUT	EF	ESP	IRATO	RY	F	AILL	2r	く上			
	at sit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as		,									
	ecute and trans	tam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Acute Myocardial Infarction Due to (or as a consequence of):												
Ö,	sian a	<u> </u>	Due to (or as a consequence of):												
68760,	icate be executed physician and the burial-transit	ica		d											
õ	ertific ing p	Mec	IF FEMALE:									1			
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 \subseteq Live birth			Ectopic pregnanc	:v				23d. Date			
<u>.</u>	ed fo	sici	1 ☐ Yes 2 ☐ No	4 ☐ Pregnant a			Other (specify)	,				Mont	h	Day Year	
P. O.	uires that the de signed by the a d be detached f	پار	9 ☐ Unknown	3 LI CHIMIDWIT	_										
Ś	gned gned	by	Part II. Other significant condition	ons contributing to death b	ut not resu	ılting in the ur	nderlying cause giv	en in Part	t.	23e. Did	tobaco	co use contrib	ute to the	e cause of death?	
Records,	w requir s been si should b		-							10	Yes	2 □ No 3	☐ Proba	ably 4 Unknown	
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ď	The law cate has page 2 a	lmo									ormed	? / de	ath?	npletion of cause of	
<u>a</u>	sician: Th certificate rector, pag	a)	25. Was case referred to medica	1				26 Plan	o of Dogth	☐ 1 ☐ Yes (Check only		No 1L	Yes	2 LL/No	
>		0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: i	ent 2 🗆	ER/Outpatien	t 3 DOA Oth	0.51				0 000			
Division of Vital	a Phys er this eral dii	\vdash	27. Manner of Death	28a. Date of Inju	ıry	28b. Time of	28c. Injur	y at				6 □Other		<u></u>	
0	ding F th. : After e funera	흝	1 Natural 5 Pendir 2 Accident investi		ıy, Year)	Injury	M 1 🗆	k? Yes 2.⊑]No			, , , , , , , , , , , , , , , , , , , ,			
2	• Attend er death • ector: , by the f	lica	3 ☐ Suicide 6 ☐ Could	not be 200 Place of Ini	ury - At ho	me, farm, stre	eet, factory, office			Sf. Location /	(Street	and Number	or Ruml	Route Number,	
2	after after Direction by	Certification:	4 ☐ Homicide determ	building, et	c. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or To	wn, St	ate)	or marai	route rumber,	
	spital or nours afte neral Dir / filled in		29a. Certifier 1 Certifyir	ng Physician: To the best	of my know	wledge, death	occurred at the tir	me, date a	and place, a	nd due to the	e caus	e(s) and man	ner as st	ated	
	To the Hospital of within 24 hours af To the Funeral D Completely filled in	Medical	(Check only 2 ☐ Medical one)	Examiner: On the basis of and manner st	of examina	tion and/or inv	estigation, in my o	ppinion, de	eath occurred	d at the time	, date	and place, an	d due to	the cause(s)	
	Vithir Nomp	ME	29b. Signature and title of certifie	7	,		29c. Licens	e number			29d.	Date signed (Month, E	Day, Year)	
			A LEV	9sawant	vz,	MD	D5	94	18		MI	MAY 1, 2008			
	13		30. Name and address of person	who completed cause of a	leath (Item	23a) (Type I		- 1					•		
			ADFULLN	MI, MI	-44	EMIC	>1 W1) 10	HOI Pri-	nce Ph	اندال	Dr. 1)lno	1 E 805 Q M A	
	Sta	e	31. Date filed (Month, Day, Year)	2. Registr	ar's Signat	ure	1 17	13	101111	100 111	· Hif-	107. 0	1115	7 . 1. 0 208 75	
	Registra		MAY 0 6 2	2008	. As	Anga	E)								

For AMEND10b, perFH, 5/9/08, DFS, MOO
Registre/MEND#10bperFH5/6/08, BMW, MOO
Certificate of Death
Reg No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 10:05 a M Barbara Eaton Ferguson 2008 May 01 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death Renaissance Gardens-Riderwood Nursing Home Prince George's Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F Director 097-22-8814 81 April 22, 1927 Utah Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If filed x 1s marked other than "nature!" -- " any injury or other trainment." 10b. CountPrince George's 10a. State 10c. City, Town or Location 10d. Inside City Limits Montgomery 1 ☐ Yes 2 K No Director Maryland Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3156 Gracefield Road, #op505 20904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify. Specify. \$ 3 XWidowed 4 Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Eaton Katherine Duncan မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Gerecht - Daughter 113 Crystal Spring Drive, Ashton, Maryland 20861 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 05/09/2008 Brentwood, Maryland 21. Signature of Euneral Service Licensee. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. XV 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 days Metabolic Acidosis /Medical Due to (or as a consequence of) Examiner Chronic Renal Failure 10 years Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the attending IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 № Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA မ 1 ☐ Inpatient this 28a. Date of Injury (Month, Day Year) After t 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 5 ☐ Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 👿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Vithin 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and ti D24093 May 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Parkhurst, M.D., 3110 Gracefield Road, Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 0 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** Helen G. Frank April 29 12:36 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🖾 F Director 579-28-6204 7/18/1928 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examirer must be rollfied at Director 1KIYes 2 □ No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 Funeral 5801 Nicholson Lane #1635 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No <u>ک</u> Specify. Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Computer Coordinator U.S. Government permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Maurice Levy Rose Ackerman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Frank - Son 10600 Montrose Avenue #202 Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 Donation 5 Dother (Specify) King David Mem. Gdns. 5/1/2008 Falls Church, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. Rockville, MD 20852 1091 Rockville Pike 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Multi Organ System Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Coagulapathy Sequentially list conditions, if any leading to firm ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dise to (or as a nonsequence or, Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Year Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐ Yes 2 🖾 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Lapatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Aatural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital or Attending Physician; The law requires that the death certificate be executed burial-trai Division of Vital Records, P.O. Box 68760, attending physician the ō ned by the a signed l been s has After this filled in by the funeral after death within 24 hours a

To the Funeral L

and

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

(Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

May 1, 2008

Bethesda, MD 20814

State of Maryland / Department of Health and Mental Hygiene amend #17 Per FH G879 5/30/08 III 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 1213 Alberta Josephine Goldsborough 02, Z00 8 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Washington County Hagerstown 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛚 F 220-26-5552 97 **Director** May 11,1910 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ♣ No Directo Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 U.S.A. 1304 Pennsylvania Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: þ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Clothing Store 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Harvey Cleveland Snook Julia Viola Gossard Snook 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Monna Goldsborough-daughter 12013 Crystal Falls Dr. Smithsburg, MD 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Cedar Lawn Mem. Park 5-6-2008 |Hagerstown, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 23a. Part1. Enter ty. disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high failure. List only one cluse on each line. 1331 Eastern Blvd. North Hagerstown, MD 21742 Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) neumoni **Physician** /Medical Due to (or as a consequence of) e Mont **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 npatient Certification: To this 28a. Date of Injury (Month, Day within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral o 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05-03-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Opa 1 Court Hager Hown, mo 21740 05H-4 Waseem, mo Muhammad 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 5 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Year **Physician** MARJORIE VIRGINIA GETRIDGE MAY 2008 11:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOMEWOOD RETIREMENT CENTER WASHINGTON WILLIAMSPORT 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, **Funeral** Year) Months Days Hours 1 □ M 2 🕅 F Director 214-23-1603 86 MARCH 28, MARYLAND Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 No Director MARYLAND WASHINGTON WILLIAMSPORT the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 16505 VIRGINIA AVENUE 21795 U.S.A. Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any lnjury or other traumatic across the page 1. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No Specify ş Specify: 3 X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ HARRY GRIMM MARY HUTZELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEANNA L. NALLEY/GRANDDAUGHTER 11114 GLENSIDE AVENUE, HAGERSTOWN, MARYLAND 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 5/07/2008 4 Demotion 5 ☐ Other (Specify) BOONSBORO CEMETERY BOONSBORO, MARYLAND 22. Name and Address of Facility 22. Name and Address of Facility 7606 BAST-STAUFFER FUNERAL d National Pike E. P.A. HOME, P.A. Boonsboro Paul M. Dean MD 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending 1 □Yes 2 □No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapper stated. 29a, Certifier Medical (Check only one) To th. 29b. Signature and State Registrar

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A second		Kenneth Hi 4a. Facility Name (if not institution	nton on, give street and r	number)		4b. City, Town, o	r Location of E		4c. County of E				
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Baltimore, permit. Pages 1 an Department of Hea Important: If iter njury or other tra		20a. Method of Disposition 1 X Burial 2 Crematic	n 3 Removal	from State	rematory or	other place)		5/ 20 /2008					
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the H thin 24 the Fi	Medical	(Check only one) 2 Medical Ex	aminer: Of the bas	sis of examination a	ge, death oci ind/or investi	gation, in my opin	ion, death occ	urred at the time, da	te and place, and du	e to the cause(s)			
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(IR I)		Mary G. Ripple MD. 31. Date filed (Month, Day, Year		ef Medical Exa			et, Baitimo	ore, MD 21201					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Preston W. Harris May 2008 1923 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 7. Age (In yrs. last birthday)

Nov. 30, 1924 Birthplace (State or Foreign Country)
 MD 1 ☐ M 2 ☐ F 216-18-5447 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 Tillo MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1825 Joe Harris Road 20678 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Federal Government College (1-4or 5+) Boiler Plant Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isaac Harris, Sr. Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice E. Harris/wife 1825 Joe Harris Rd. Prince Fred.,MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Removal from State Carroll West. Cem. 5/8/2008 Pr. Fred., MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Fred., MD20678 21. Signature of Funeral Service Licensee Blady 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscienotic Cardio Voscelardisease disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the pasi 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? Coronary Aytery disease 1 Yes 2 No 3 Probably 4 Onknown Diabetes mellitus. 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Road

29c. License number 50653

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29d. Date signed (Month, Day, Year)

5-1-2008

Examiner use as the burial-transit The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-trar Division of Vital Records, P.O. Box 68760, signed by the this certificate After this certification funeral director, hours after death. filled in by the

To the Hospital or Attending Physician: within 24 hours a To the Funeral D

Physician

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29a. Certifier

Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f ehow traumatic event, the Madical Examinar must be notified at

with the Maryland

72 hours after death

Pages 1 end 2 should be filed within nent of Health and Mental Hygiene int: If item 27 is marked other than '

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permit. Pages Department of Important: If it any Injury or o

Physician

/Medical

Baltimore, Maryland 21215-0036

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) 2 2008 MAY

eyar

29b. Signature and title of certifier



Surana

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2008	1.10
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1	/Medio			
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G	or Iten	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \[\text{Never Married} \] Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.} \] 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 \[\text{Yes} \] Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.} \] 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Specify: White	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ther, the Medisal Examiner must be notified at	d by	3 Widowed 4 Divorced Year or Dates:	
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Yea	
	Mi Wi		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yea 05-03-206	8
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Regist/MEND#5, perFH, 5/13/08, DPS, Mode Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Lana Elaine Hamilton 6:49 pM May 04 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 32-2972 Months Days Hours Min. 1 M 2 X F March 20, 1941 New Jersey 67 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 13102 Brittany Drive 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify. Specify: American-Indian 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Rufus Morse Doris Vivian West 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond H. Hamilton - Husband 13102 Brittany Drive, Silver Spring, Maryland 20904 20a. Method of Disposition Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 Removal from State 05/09/2008 4 ☐ Donation 5 ☐ Other (Specify) Rosedale Cemetery Montclair, New Jersey 21. Signature of Euporal Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischemic Cardiomyopathy Unknown disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Renal Failure, Hypotension, Peripheral Vascular Disease, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes Mellitus, Left Foot Gangrene & Osteomyelitis autopsy performed' 2 🗓 No 2 🗆 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 2 Accident 1 Yes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

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e Hospital or Attending P 124 hours after death. e Funeral Director: After t completely To the P within 24 To the F

State

Eric Joon-Shik Park, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) MAY 0 6 2008

determined

Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0060117

29d. Date signed (Month, Day, Year)

May 5, 2008

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month May 1,2008 10:05p ^M Martha Hickman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Casey House, Montgomery Hospice Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec 28,1910 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2X F Virginia Director 97 577-40-3543 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shi any Injury or other traumatic event, the Medical Examiner must be notified a once. Director MD 1 XYes 2 No Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 United States 407 Russell Ave, #801 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo 3 ∰Widowed 4 ☐ Divorced Specify: þ White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Mauzy ပ Uriah Hevener 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Wood/Daughter 11847 Antietam Rd, Woodbridge, VA 22192 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 5-6-08 Falls Church, Va National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Libensee 22. Name and Address of Facility Joseph Gawler's Sons, INC 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Advanced Cancer of Vulva disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? /es 2 XNo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? v Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 No 2 Accident Director: A in by the f 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie cal one To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D00064615 May 2,2008 30. Name and address of person who completed cause of death (liem 23a) (Type, Print) $m{\mathscr{G}}$ enevieve Wroblewski, M.D. 6001 Muncaster Mills, RD Rockville, MD 3 Registrar's Signature 34. Date filed (Month, Day, Year) MAY 0 6 2008 Registrar

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mes W. Hugh		- For State Certifica	nt of Health and Mental te of Death	Hygiene	200	8 64							
Physicia	ın/	1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death							
edical Exami		James W. Hughes, III	Lu au au au au au au au au au au au au au	Month April 29, 200	08	2153 hrs							
		4a. Facility Name (if not institution, give street and number) 201 N. North of Cherry Hill Lane	4b. City, Town, or Location of De Beltsville	eatn	4c. County of Death Prince George	's							
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth			(MM/DD/YYYY) 9. Birt	hplace (State or							
Director		$214-04-1714$ $_{1}X_{M}$ $_{2}_{F}$ 24	Yrs. Months Days Hours	June1.	3,1983 Con	Meryland							
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Montal Hygiewier manural", or items 23a or 28a-f sho traumatic event, the Medie-Il Examiner must be notified at once.		424 Nevada Avenue, #4	21113		United Sta								
ath wi	Funeral	11 Marital Status 12 Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 		14. Race - Ameri White, etc.	can Indian, Black,							
ifter de il", or per mu	y Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		Specify:	White							
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MOF Pages nent of unt: If		1 XBurial 2 Cremation 3 Removal from State FORT	Lincoln Cemetery 5	5/5/2008	Brentwood	, Maryland							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hour Department of Health 2 should be filed within 72 hour Important: filtem 27 is marked other than "nati- injury or other traumatic event, the Medie Exa-		21. Signature of Funeral Service Licensee	Bonald Address of Facility 4400 Powder Mill	dt Funera	l Home, PA								
Physician	-	Donald V. Bayerath 23a. Part I. Enter the disease, or complications that caused the death. Do no	t enter the mode of dying, such as cardi	ROAD Belt: ac or respiratory arres	SVIIIE, Ma:	ryland20/05 Approximate Interval							
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries				Between Onset and Death							
xaminer		or condition resulting in death) Due to (or as a consequence of):											
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outed nd ransit		events resulting in death) Last Due to (or as a consequence or): d.											
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	sician/Medical	UNPENDED AMENDED											
68761 certificate nding phy	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy	Fetal death 3 Ectopic pro	egnancy	23d. Date of deliver Month	y Day Year							
Box 6876 death certificat the attending phy	sicia	past 12 months? 4 Pregnant at time of death 5	_										
D. B. tr the de by the	Phy	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	. 23e. Did tot	pacco use contribute to	the cause of death?							
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of Ving Phys	5	27. Manner of Death 28a. Date of Injury 28b.	itpatient 3 DOA Other N Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred								
ion (tending eath. or: Al	tion	1 Natural 5 Pending Apr 29, 2008 Apr 29, 2008 2131	hrs 1 Yes 2 No	Occupant au	ito fixed object co	ollision							
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	rm, street, factory, office building, etc.		treet and Number or R ate) if Cherry Lane, Belts	ural Route Number, City							
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To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	red at the time, date a	and place, and due to t	he cause(s)							
F » F »	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mi	onth, Day, Year)							
5		Don mulinh in is	O.C.M.E.		April 30, 2008								
1		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner	111 Penn Street, Baltimore	e, MD 21201									
	tate	31. Date filed (Mark Day Year) 2008 39 Registrar's Signature	hout ?										
Regis													
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State Registrar

Tahmina K. Ahmed, M.D.; 831 University Blvd. East; Suite 27; Silver Spring, Maryland 31. Date filed (Month, Day, Year)

MAY 0 7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Harold Ronald Hughes 2008 6:30A M May 5, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorchester Hurlock 6720 Bobtown Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year May 26, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 MM 2 ☐ F 60 218-48-6595 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State la or 28a-f show t be notified at Hurlock 1 ☐ Yes 2 No MDDorchester Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code United States 21643 6720 Bobtown Road "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 66 – 68 1 X Never Married 2 Married Specify: Black Saltimore, Maryland 21215-0036 1 ☐ Yes 2/☐No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation event, the Medical (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 h and Mental Hygiene.
7 Is marked other than "n. College (1-4or 5+) Poultry Line Processor 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Mae Robinson John Arthur Hughes, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s nent of Health an 6720 Bobtown Road, Hurlock, MD 21632 Elsie Mae Hughes/Mother item 27 l 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If its any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Eastern Sh. Veterans Cem. 05/09/08 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licensee Eskow 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acore Myocardial
Due to (or as a consequence of): Infarction Minutes Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical the. use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the at the detached for ☐Yes 2☐No Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pulmonary obstructive 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Substance 25. Was nace Abuse certificate 1 Yes 2 No Division or Vital To the Hospital or Attending Physician: Was case referred to medical examiner? funeral director. Be 26. Place of Death | Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation s after dec. 1 Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 05,05.2008 D42005

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State Registrar Chesapealu Dr.

830

Cambridge, MD 21613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 Pear May **Physician** 4, 8:00P. Pau1 Imle, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Bowie Assisted Living Bowie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth October 154, 1910 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** Months Days Hours Min. Illinois 1X M 2□ F 97 218-38-9885 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show if than "natural", or items 23a or 28a-f show the Medical Example in ust be notified at Silver Spring Maryland Montgomery 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number United States 3112 Gracefield Road, #T22 20904 Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, Its Medical Examples in mast 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No White Baltimore, Maryland 21215-0036 Specify Specify. 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tropical Crops Specialist U.S. Dept. of Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clara J. Coldren Frederick Christian Imle 2 19a. Informant's Name/Relationship (Type. Print)
Portia Mollard Imle -wife 19b. Mailling Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 3112 Gracefield Road, #T22 Silver Spring, Md. 20904 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 5/7/2008 20c. Location - City or Town, State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Ma 21. Signature of Funeral Service Licensee Maryland 20705 23a. Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial Infarction hours disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Atherosclerosis vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. physician and the burlal-trans Coronary Artery Disease years resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Þ Hypertension; Advanced Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2X No 1 ☐ Yes 2X No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Xother (Assisted Living Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral 27. Manner of Death 1 🕅 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, in 24 hous on the Funeral Discompletely filler

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

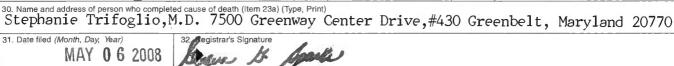
4 Homicide

(Check only one)

29a Certifier

Medical

MAY **0** 6 2008



and manner stated.



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

May 6, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

oward Jackson		I- For State Criticate of Death	Reg. N	201	18 1642						
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	Date of Death Month Da		3. Time of Death						
edical Exami	ner	Howard L. Jackson	May 3, 2008	4c. County of Dear	1015 hrs						
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Southern Maryland Hospital Clinton		Prince Georg							
Cumaral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth(N	1M/DD/YYYY) 9. B	irthplace (State or						
Funeral Director		579-78-6145 1x M 2 F 52 Yrs. Months Days Hours Min.	Aug.22	,1955 W	ountry) ash ,DC						
any	ŀ	Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County			10d. Inside City Limits						
* "	اي	Md. PG Capitol Heights			1 XYes 2 No						
daryland 28a-f show dat once.	Director	Md. PG Capitol Heights 10e. Street and Number 10f. Zip Code	10g.	Citizen of What Co	untry?						
the Na or 2		1117 Brooke Road 20743		nited S							
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and bental Hygiers tearly and bental Hygiers tearly and mental Hygiers travmatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 15. Married Forces) 15. Was Decedent of Hispanic Origin	ecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,						
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72 hou n "nat	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired to the control of the control	red)								
5-0036 iled within 7 Hygiene. I other than the M dica	E G	5+ Home Improvement C			rivate _						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte begartnent of Health and Mental Hygiers. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	ပ	The attention of the state of t	(First, Middle, Mai								
2121 2121 Juld be fi Mental marked ic event,	To Be	John W. Jackson Blanch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	le <u>Litt</u> Rural Route Numbe	上色 r, City or Town, Sta	ite, Zip Code)						
MD 2 d 2 shou lth and I n 27 is r		Katherine Jackson/wife 1117 Brooke Road Capital Heights, M 20a. Method of Disposition (Name of cemetery, M	ID 2074	2							
e, N 1 and Health item			Date 2	೦c. Location - City	or Town, State						
TOF Pages ent of nt: If		A Donation 5 Other Specify Md. Veterans Cem. 5/8	1/08	Chelten	ham, Md.						
Baltimore, permit. Pages I ar Department of Hes Important: If ite		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hod	lges & E	dwards	F.H.						
D 9 9 1 1 1	2 10	23a/Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	I Rd .	Suitlan	d. Md. 20746 Approximate Interval						
Physician Medical		Vailure, List only one cause on each line.	respiratory arrest	, SHOOK, OF HEAR	Between Onset and Death						
xaminer	r ii	Immediate Cause (Final disease or condition resulting in death) Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):									
		Sequentially list conditions, b									
	iner	if any, leading to immediate Due to (or as a consequence of):			1						
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ecuted and transi		d									
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. The rhis certificate has been signed by the attending physician and pipeley filled in by the furneral director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED AMENDED		23d. Date of deliv							
8760, ificate bug physic	N/M	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnance	ancy								
Box 687: death certific	icia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)									
Bo he dea y the a	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute	to the cause of death?						
, P.O. Erres that the d signed by the be detached	ğ	Part II. Other significant conditions continuously to death but not recording in the cheering seems give in the	1 Yes	robably 4 🗸 Unknown							
cords, F aw requires as been sign 2 should be	Completed		24a. Was an		autopsy findings available to completion of cause of						
Cords law requi	ď		autopsy perform	ed? death	1?						
Vital Recysician: The his certificate director, page		25. Was case referred to medical 26.Place of Death (Check									
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Clospita hours unera		29a. Certifier	d due to the cause	(s) and manner as s	stated.						
Divisi To the Hospital or At within 24 hours after de within 24 hours after do not be to completely filled in by	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date ar	nd place, and due to	o the cause(s)						
7 wi.	ğ	29b. Signature and title of certifier 29c. License number	1	29d. Date signed ((Month, Day, Year)						
		Patrici armi - Blld vs O.C.M.E.		May 4, 2008							
0		30. Name and address of person who completed cause of death (Item 23a)	MD 21201								
NO			7.0, IVID 2 1201								
Regis	tate strar	MAY A 7 4000 F. I Le Falle									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

arles Jones		State of Maryland / Department - For State Certificate							
· ·		Registrar 1. Decedent's Name (First, Middle,Last)	Of Death	Reg. No	3. Time of Death				
Physicia dical Exami	-	Charles Jones		Month Day Year April 29, 2008	0250 hrs				
Ç Ç		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1 4c. County of D					
		Bock Road & Holly Drive	Fort Washington	Prince Geo					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		— IE	Birthplace (State or USA				
Director		343-74-9987 1× M 2 F 36	Yrs. Months Days Hours Min	05/20/1971	Country) USA				
	1	Usual Residence of Decedent			10d. Inside City Limits				
any		1 10a. State 110b. County 10c. City, Town or Location							
and show	៦	laryland Plince Georges ye, was		10g. Citizen of What	1 X Yes 2 No				
Maryland 28a-f show	Director	10e. Street and Number	10f. Zip Code 20744	USA	Country :				
the Na or	ö	7501 Jaffrey Road			merican Indian, Black,				
h with	Funeral	Armod Formes?	Was Decedent of Hispanic Origin? (SIf Yes, specify Cuban, Mexican, Puerto	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
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s after ral",	by	3 Widowed 4 Divorced If Yes, Give Year 990-1993 1 15. Decedent's Education (Specify only highest grade completed) 16a. Dec	edent's Usual Occupation (Give kind of		ess/Industry				
hour natu	ted	durin	ig most of working life. DO NOT use re	etired)					
36 tin 72 than dical	ble	12th Fede	ral Protection	Officer CI	A				
d with	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Nam	ne (First, Middle, Maiden Surname) ne Holmes					
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be (Charles Jones							
Me Me	2	19a. Informant's Name/Relationship (Type, Print)	ailing Address (Street and Number or 1 Jaffrey Rd, F	Rural Route Number, City or Town, t. Wash, MD 2074	State, Zip Code) : 4				
MD and 2 sho alth and m 27 is aumati		Diletta III della		Date 20c. Location - C					
Fe, land FHeal		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Mary La	sposition (Name of cemetery, or other place)		nham, MD				
Pages ent of									
Baltimore, permit. Pages I an Department of He Important: If ite		21 Signature of Euperal/Service Licensee	22. Name and Address of Facility 65 Strickland Fune	00 Allentown	Ra,				
0 897 :									
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.	iter the mode of dying, such as cardiac	or respiratory arrest, errost, er reserv	Between Onset and Death				
'Medical xaminer	4.1	Immediate Cause (Final disease a. Multiple Injuries							
		or condition resulting in death) Due to (or as a consequence of):							
	ᡖ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			14				
	튙	cause. Enter Underlying Cause (Disease or injury that initiated							
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Box 6871 death certifics the attending p	Sicia	4 Pregnant at time of death 5	Other (Specify)						
Bo ne dea the a	1 €	a Ja John Mill	the underlying cause given in Part I.	23e. Did tobacco use contrib	ute to the cause of death?				
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ords, wequir as been s	Completed			performed? de	ior to completion of cause of eath?				
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To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or inv	estigation, in my opinion, death occurre	ed at the time, date and place, and di	ue to the cause(s)				
To t With To t	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		ed (Month, Day, Year)				
	-	Canadalanna	O.C.M.E.	April 29, 20	80				
		30. Name and address of person who completed cause of death (Item 23a)							
A (6)	1	Carol Allan, MD Assistant Medical Examiner 111 P	enn Street, Baltimore, MD 21	201					
	State	22 Pegistrar's Signature	1944						

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			For State Registrer	State of	Maryland		irtment of I		Mental Hygie	200	8 1642	2
	Physici	an	Decedent's Name (First, Middle, Last, Vera Ka				-		2. Date of Death Month April 29	Day 2008	3. Time of Death) M
•	/Medio Examin		Vera Katine 4a. Facility Name (If not institution, give street and number) Hebrew Home of Greater Washington Ab. City, Town, or Location of Death Rockville									
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	Ba-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Montgome	ery		,Town or Lo					10d. Inside City Lim	
	3a or 2	I Dire	10e. Street and Number 6121 Montrose Road	l			10f. Zip Code 2085	2		Citizen of Wh	•	
90036	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It am arked other then "naturel", or items 23a or 28a-f show traumatic event, the Medical Examinar must be multiled at	d by Funeral	3 X Widowed 4 ☐ Divorced	12. Was Deceded Armed Force 1 Tyes 2 If Yes, Give Year or Date	ent Ever in U.S es? PANo es:		☐ Yes 2Ă No			Black, Specify:	American Indian, White, etc. White	
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yland	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Sam Fishman					18. Mother's Nam Anna Bat	ne (First, Middle, Mai 1erman	den Surname)		
Mar	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Ty Carrol Perrino - I			19b. Mailin	g Address <i>(Str</i> eet Ednor Ro	and Number or Ru ad Silve	ral Route Number, C r Spring M	ity or Town, Si D 2090.	tate, <i>Zip Cod</i> e) 5	
Baltimore, Maryland 21215-0036	- F E E		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 ☒ F 4 □ Donation 5 □ Other (Specify)		ate C6	emetery, cren	sition (Name of natory or other pla Cremator	1			ity or Town, State urch, VA	
Balti	permit. Page Department o Importent: if any injury or once.		21. Signature of Fune al Tvice Licens	**	7-		Name and Addre		al Directi ke Rockvil	on Inc	20852	
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XX rds, P	quires thet an signed b uld be deta	þ	Part II. Other significant conditions cor HYPERTE	N $S(0N)$	h but not resu	ılting in the ur	iderlying cause giv	ven in Part I.	23e. Did tobac		ute to the cause of death?	
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Divis	Ital or Atters after der ei Directo	Certification;	3 Suicide 6 Could not be determined	28e. Place of building	Injury - At ho	me, farm, stre	eet, factory, office		28f. Location (Stree City or Town, S		or Rural Route Number,	
	ne Hospi n 24 hou ne Funer bletely fill	Medical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sicien: To the bener: On the basi and manner	s of examinati	wledge, death ion and/or inv	occurred at the ti estigation, in my o	me, date and place, opinion, death occur	, and due to the caus rred at the time, date	e(s) and mann and place, an	ner as stated. d due to the cause(s)	
4	S Virial S	×	29b. Signature and title of certifier	xeu	ais		29c. Licens	se number 18084			Month, Day, Year)	
			30. Name and address of person who co	mpleted cause	of death (Item		Print) HONE TO	rose Ry	o Rock	ulle,	402085	
÷	Sta Registr	_	31. Date filed (Month, Day, Year) MAY 0 6 2008	Reg	istrar's Signat		de la					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician 2008 4:50 A April 29, S. Frances Katz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda if Under 1 Year | if Under 24 Hrs. 8. Date of Birth

July Pro Year 1914 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 001-32-3625 1 M 2 F 93 Ukraine Vre Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1▼Yes 2 No Director MD Montgomery Rockville 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 1799 East Jefferson Street 20852 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 √2 No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Rusiness/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Weight Control Business Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Unknown h and Menta Unknown Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any Injury or other traum once, Janet L. Katz - Daughter-in-Law 8605 Hidden Hill Lane Potomac MD 20854 20b. Flace of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5/1/08 Olney, MD Judean Mem. Gardens 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Edward Sagel Funeral Direction Inc 1091 Rockwille Pike Rockwille MD 20852 23a. Part1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final 5 Days **Physician** Renal Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Urinary Tract Infection 5 Days Sequentially list conditions, if any to find the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 5 Days Pleural Effusion use as the burial-tran Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 X No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♣ No 24a. Was an autopsy performed? page 2 The 1□ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 31. Date filed (Month, Day, 0 6 2008

waharren

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier





29c. License number

D0066003

29d. Date signed (Month, Day, Year) April 29, 2008

Baltimore, Maryland 21215-0036

Records,

Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2003 April **Physician** .Tames Keane 30, 9:30P. Emest /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beltsville Prince George's 4632 Quimby Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, 20, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year 936 Washington, DC Months Days Hours Min. 579-46-2469 71 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Beltsville Maryland Prince George's 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 20705 United States 4632 Quimby Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Black, White, etc. White Race - American Indian. 1 XYes 2 No If Yes, Give Year or Dates: unknown 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. ģ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (012) College (1-4or 5+) Local 265 Printer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Bernice Botts Be Henry Keane Bernice ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4632 Quimby Avenue Beltsville, Maryland 20705 19a. Informant's Name/Relationship (Type. Print) Brenda L. Newberry -daughter 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 5/1/2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA De con 4400 Powder Mill Road Beltsville, Mar<u>yland 20705</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 14 years Immediate Cause (Final Prostate Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d, Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒No 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{\text{N Residence}} \) 6 \(\text{Other (Specify)} \) 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred

signed by the attending physician and I be detached for use as the burial-tran certificate has been s rector, page 2 should To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mertal Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a by 28a-f show any or other traumatic event, Ite Mexical Exp. injust the restinct at my or other traumatic event, Ite Mexical Exp. injust the restinct at

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Examine Physician/Medical Be

Completed by

Certification: To

27. Manner of Death 2 Accident 3 Suicide

4 Homicide

29b. Signature and title of certifie

29a. Certifier

5 ☐ Pending investigation 6 ☐ Could not be

determined

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and and see so of person who completed cause of death (Item 23a) (Type, Print)

Clement B. Knight, M.D. 11065 Little Patuxent Parkway Columbia, Maryland 21044 31. Date filed (Month, Day

State Registrar egistrar's Signatur



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death George John Keto **Physician** 8:30 A M May 5. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 7007 Meadow Lane Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Months Days 86 1X M 2 ☐ F 12/20/1921 288-16-4552 Ohio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland | Montgomery 1 TYYes 2 □ No Chevy Chase Director 10e. Street and Number 7007 Meadow Lane 10g. Citizen of What Country? 10f. Zip Code 20815 United States Funeral 14 Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Types 2 No 1944− if Yes, Give Year or Dates: 1946 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Attorney <u>Federal Government</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kosti Keto Helmi Ravinen 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) David Keto / Son 7010 Hillcrest Place Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 【X Removal from State National Crematory 05/07/2008 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee ALVOW lask 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 5 Minutes Immediate Cause (Final Cardiac Arrhythmia disease or condition resulting in death) Due to (or as a consequence of): Chronic Atrial Fibrillation 15 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed

Physician /Medical Examiner

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or idical Examiner must be i

traumatic event, the Medical

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If them 27 is marked other than "ne any injury or other traumatic event than "ne once.

filed within 72 hours after death with the I Hygiene.

Baltimore, Maryland 21215-0036

Box 68760.

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Division or Vital Records,

or Attending

death.

after

To the Hospital o within 24 hours aft To the Funeral Di

executed death certificate be

nding physician and use as the burial-tran nse atten for u the signed by t page 2 has this certificate funeral

Be

၉

Certification:

Medical

Chronic Anticoagulation

6 ☐ Could not be

determined

24a. Was an autopsy performed?

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

31. Date filed (Month, Day, Year) MAY 0 6

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b Time of 5 Pending investigation

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Other: 4☐ Nursing Home 5 ★Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

2x No

29a. Certifier

1X Natural

2 Accident

3 Suicide

4 ☐ Homicide

1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number ·D07147

29d. Date signed (Month, Day, Year) May 5, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wisconsin Ave. #730 Chevy Chase, MD 20815 Allen Nimitz MD 5530

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

32 Registrar's Signature

To the Funeral Director; After completely filled in by the funer.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 7:30 A M 3, 2008 Gertrude Bland Knight May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 2010 Bart Court Upper Marlboro Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1/7/1917 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** 241-76-1911 Days Hours Min. 1 ☐ M 2X F 91 NC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD 1t∑Yes 2 No Prince George's Upper Marlboro Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2010 Bart Court 20774 USA Funeral 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: þ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Own Home Housewife d 2 should be filed w h and Mental Hygiei 7 Is marked other ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Bland Penny Elizabeth Pugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau
once. Cassandra Baker/Daughter 2010 Bart Ct., Upper Marlboro, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Knight Family Cemet. 5/12/08 Ernul, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Strickland Funeral Services, Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed ician and burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical the as attending p 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. the 9☐ Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 1☐ Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Mesidence 6 ☐ Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 ☐ Yes this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Funeral Director: After completely filled in by the funera Certification: To the Hospital or Attending within 24 hours after death. (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) se of death (Item 23a) (Type, Print) A Greenbelt, md. 20770 State Registrar

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5, \mathbf{P}^{M} Warren Clark Lamson 2008 11:05 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11450 Asbury Circle, Unit 126 Solomons Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 20, 1914 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Min. 1**X** M 2□F 506-12-3070 Director Nebraska Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2XXNo Director Maryland Calvert Solomons 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be re-11450 Asbury Circle, Unit 126 20688 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1₩ Eves 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ 12 should be filed w h and Mental Hygier 7 is marked other th Psychiatric Social Worker US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Wesley Lamson Laura Alice Frady 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iges 1 and 2 so it of Health an Julia Louise Lamson / Wife 11450 Asbury Cr., Unit 126, Solomons, MD 20688 altimore. Department of Hee Important: If itemany initial 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 5/07/08 Alexandria, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical the as IF FEMALE use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1∐ Yes 2010 1 ☐ Yes 2 □ No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🗌 Yes 21 LAK 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending within 24 hours after death.
To the Funeral Director; After Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of con 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan K. Fears, MD 110 Hospital Road, Suite 310, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registras Signature State 2008 MAY Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11:00^{P м} **Physician** 2008 May 4 Julia Lillian Lancaster /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner Washington Williamsport Homewood at Williamsport If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. (Month, Day, real) February 10,1913 Year) Days 1 □ M 2X□ F Maryland 95 219-20-2301 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show other traumatic event, the Medical Eventians quartible notified at 1X Yes 2 No Director Hagerstown Marvland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò death with 21742 U.S.A. 1037 View Street 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: ģ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Manufacture Clerk marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental F Be should be Julia Humphrey Luther Lancaster Mary John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit, Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau 93 Cunningham Drive, Falling Waters, W.Va. 25419 Bell Sr Frank W. Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery | 05-07-08 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Andrew K. Coffman Funeral Home, Inc.
40 East Antietam Street, Hagerstown, Md. 21740 21. Signature of Funeral Service L Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Year **Physician** disease or condition resulting in death) /Medical Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed aftending physician and for use as the burial-transit Due to (or as e consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 □Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 □Yes signed by the a Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown icate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate he 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 412 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

State Registrar 29b. Signature and title

29c. License number

26800

29d. Date signed (Month, Day, Year)

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:36 PM Virginia Del1 Meredith May 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1811 Inverness Way Dunkirk Calvert If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Dec 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year) 1 □ M 2 😾 F Virginia 578-01-6330 95 1912 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Calvert Dunkirk 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 1811 Inverness Way 20754 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: þ 3 ₩ Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Beautician beauty 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rudy China Catherine 0rrJohn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1811 Inverness Way, Dunkirk, MD Grace M. Jarboe, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woods UMC Cemetery 05-10-2008 Chesterfield, VA Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 20736 8325 Mt. Harmony Lane, Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** 050 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🖘 o Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐Unknown 9 Unknown Completed by s certificate has t director, page 2 s funeral director, Be Medical Certification: To

or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in the formal completely fille

art II. Other signific	cant conditions	ontributing to death but not res	23e. Did tobacco use contribute to the cause of death?							
					_	1 □ Yes 2 □	No 3□ Probably 4□Unknown			
					-	24a. Was an autopsy performed? 1 Yes	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No			
25. Was çase referre	ed to medical	26. Place of Death (Check only one)								
examiner? 1 ☐ Yes	No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Manner of Death Natural 2 Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	280	d. Describe how injury	/ occurred			
3 ☐ Suicide 4 ☐ Homicide	6 □ Could not be determined			28f	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		nysician: To the best of my known in the basis of examinant and manner stated.					and manner as stated. place, and due to the cause(s)			

arw

30. Name and address of person who completes cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Jonathan Lowenthal, M.D. 110 Hospital Road, Suite 310, Prince Frederick MD 20678 31. Date filed (Month, Day, Year)

29c. License number

D33123

29d. Date signed (Month, Day, Year)

May 7, 2008

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:30 PM APRIL 30 2008 **EULA GOFF MINOTT** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ATRIA MANRESA ANNE ARUNDEL ANNAPOLIS 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕱 F 93 OCTOBER 7, 1914 **MASSACHUSETTS** Director 033-05-8480 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐Yes 2 X No notified Director MARYLAND QUEEN ANNE'S GRASONVILLE 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number be ns 23a UNITED STATES 335 LOBLOLLY WAY 21638 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married , 01 1 ☐ Yes 2 🛣 No Specify. Specify: WHITE ģ 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) 10 HOMEMAKER OWN HOME 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ WALLACE F. WHITMARSH NELLIE ALICE WALKER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PETER MINOTT/STEP-SON 335 LOBLOLLY WAY, GRASONVILLE, MARYLAND 21638 27 If item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State MAY 1, 1 ☐ Burial 2 ▼ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State permit. Page Department c Important: If any Injury or once, CHESAPEAKE CREMATION 2008 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tia 5415 emen /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or nijury that initiated events resulting in death) Last Due to (or as a consequence of) Examine lor Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSISTED Other: 4 Nursing Home 5 Residence 6 Nother (Specify) I.IVING Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours a the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fittle of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

State Registrar 31. Date filed (Month

5

2008

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

trar's Signature

Arnold, MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Year Month **Physician** 6:15 P 28, 2008 April Ruth Miller /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 ☐ M 2 🖼 F 94 08/13/1913 New Jersey Director 063-01-4957 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at show MY Yes 2 No Director Potomac Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or: any injury or other traumatic event, the Medical Examiner must be nonee. 20854 U.S.A. 7608 Glackens Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2ሺ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify White Baltimore, Maryland 21215-0036 \$ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Novak Samuel Stein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7608 Glackens Drive, Potomac, Maryland Philip R. Miller/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Lebanon Cemetery 04/30/2008 Adelphi, Maryland 21. Signature Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🕱 No 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 1∐ Yes 2 No Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 No 1 Inpatient Division or 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27, Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed fause of death (Item 23a) (Type, Print) WISCONSINAVE, BETHESDA, HU KAVY 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 0 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Judson Ridgway Mills 5 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Doctors Community Hospital Prince George's Lanham Social Security Number 391-28-9420 7. Age (In yrs. last birthday) 76 Yrs. 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 24, 1931 6. Sex **Funeral** Months Days Hours Min 1 XM 2 □ F Illinois Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Heatth and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director Maryland | Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6830 Trexler Road 20706 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No White Specify Completed by Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)5+ Elementary/Secondary (9-12) Professor Univ. of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Judson Ridgway Mills, Sr. Lillian Ericson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Li Y Mills -wife 6830 Trexler Road Lanham, Maryland 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department o Important: If a Metropolitan Crematory 5/8/2008 | Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licenses Naneld V. Bar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rougen 1244 ediate /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to him educate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a continguence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9□Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 10 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? certificate | death? 1 Yes 2 No 2□No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

Division or Vital Records, P.O. Box 68760 within 24 hours after death To the Funeral Director:

Maryland 21215-0036

Baltimore,

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

D. Grantesto

MAY 0 6 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

115 Celyterceny

Registrar's Signature

29d. Date signed (Month, Day, Year)

Greenbelt MD 20270

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 VIRGINIA MCGINNES MAY 01 9:00A TDA /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner DORCHESTER MALLARD BAY CARE CENTER CAMBRIDGE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 👿 F 578-14-8609 87 08-14-1920 BERWYN, MARYLAND Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County Y Yes 2 No Director DELAWARE KENT DOVER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 19901 USA 156 LOTUS STREET Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items dical Examiner mu 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: Completed by WHITE 3 Widowed 4 □ Divorced Year or Dates: 16b. Kind of Business/Industry Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) the RESIDENCE HOMEMAKER 12 O 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LAURA R. BASSFORD J. EDWARD WEAVER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is no or other traun JERRY MCGINNES 5506 MALLARD LANE, CAMBRIDGE, MD 21613 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department or Important; If any injury or once. 05-02-2008 SMYRNA, DELAWARE KENT CREMATION SER. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 19901 TRADER FUNERAL HOME INC 12 LOTUS ST., DOVER DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) week **Physician** as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Examiner burial-trai Due to (or as a consequence of) Physician/Medical the as nse 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year Por in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Ď 2 00 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 autopsy perform 2 No eimers 2|Z] No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2

/Medical Examiner and Box 68760 P.0. the à Records, certificate Division or Vital this After t death. after death completely filled in by the

with the Maryland

filed within 72 hours after death

2 should be finance and Mental H

Pages 1 and 2 should be need of Health and Men

Maryland 21215-0036

Baltimore,

28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier

5 ☐ Pending investigation

6 ☐ Could not be

determined

29c. License numbe

29d. Date signed (Month, Day, Year)

ddress of person who completed cause of death (Item 23a) (Type, Print) Name and 100 Bra

Registrar's Signa

Street

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

Certification:

Medical

27. Manger of Death

1 Anatural

∠ □ Accident

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

the Hospitai or within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 3:00P 2008 May 3, Mary C. Moore /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Fort Wa Washington ear | If Under 24 Hrs. | 8. Prince Georges 10710 Valley Brook Drive 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthdav) Social Security Number **Funeral** Hours Months Days 1 □ M 2 F Aug. 18, 1932 **Director** Wash. 577-42-1482 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show notified at 1 XYes 2 No Director Md. PG Fort Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 10710 Valley Brook Drive 20744 United States 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or Items the Medical Examiner mu 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0036 Specify: ģ Black 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private <u>Advocate Writer</u> other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Pages 1 and 2 should be Maebell Ryan ပ William Lanham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10710 Valley Brook Drive Fort Washington, Md. 20744 f Health a tem 27 Is Robert T. Moore/husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 to 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Important: It any injury o Veterans Cem. 5/12/08 Cheltenham, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to for an alexansorum and off Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 5 ☐ Other (specify) signed by the a Part H. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 40 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To

Division or Vital Records, P.O. Box 68760.

certificate has birector, page 2 s

after death Director:

To the Hospital or Attending Physician: within 24 hours aft

To the Funeral DI

completely filled in

State

Registrar

31. Date filed (Month, Day,

MAY 0 7 2008

30. Name and address of perso

5 ☐ Pending investigation

6 ☐ Could not be

determined

27. Manner of Death 1 Watural

2 Accident

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

29b. Signature and title

ON

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

d cause of death (Item 23a) (Type, Print)

Injury

28c. Injury at Work?

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 □ Yes 2 □ No

iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

13-350 Fatural-

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Amend State of Maryland / Department of Health and Mental Hygiene 1 tem 2 per dr., g8/9, 05/30/08dhb.

Reg. No. 1

Reg. No. 2. Date of Death 2008

USA

\$008

QUEEN ANNE

14. Race - American Indian,

WHITE

Black, White, etc.

23d. Date of delivery

death? 1 ∐ Yes

24b. Were autopsy findings available prior to completion of cause of

2 No

Month

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

SYUNI

1 ☐ Yes 2 No

MARYLAND

12:50 P M

1. Decedent's Name (First, Middle, Last) **Physician** JOSEPH COOK MULLIKIN MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 730 HOPE ROAD CENTREVILLE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 X M 2 □ F Director 213-03-0875 JUNE 2, 1914 93 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at Director CENTREVILLE MD **QUEEN ANNE** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21617 730 HOPE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 😿 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FARMER FARMING permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygis Important: If item 27 is marked other i any Injury or other traumatic event, <u>ti</u>t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES WILLIAMSON MULLIKIN EMMA LOUISE COOK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 730 HOPE ROAD, CENTREVILLE, MD 21617 MARY T. MULLIKIN/ WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State CHESTERFIELD CEMETERY 5-6-2008 CENTREVILLE, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBÉIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1, Enter the disease, or complications like caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final **Physician** disease or condition resulting in death) MONIC /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 1☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown 2 The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an cate has page 2 s autopsy certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner La Ceath 28c. Injury at Work? 28d. Describe how injury occurred Certification: neral Director: After filled in by the funer 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and addryss of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

LUDWIG EGLSEDER TIIM.D. 503 CYNWOOD DRIVE EASTON, MD 21601

MAY 06

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:40 AM KENNETH MORRIS NEELEY MAY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL ANNAPOLIS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□ F Months Days Hours Min. JULY 14, 1924 Director KANSAS 513-14-0008 83 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 ☐ No Director **KANSAS** WYANDOTTE KANSAS CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8725 GREELEY DRIVE 66109 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces? Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1944-1946 1 ☐Yes 2 XNo Specify. þ Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 SHEET METAL WORKER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ JOHN NEELEY ZORA GARRISON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GARY NEELEY/SON 908 AUCKLAND WAY, CHESTER, MARYLAND 21619 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) **MAY 12** NATIONAL CEMETERY 2008 LEAVENWORTH, KANSAS 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. of Funeral Service I Momay 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic Adano carcinoma of Physician UNTHOWA 1 Week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 MiNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day, Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

State

Registrar

28a-f show

th and Mental Hygiene.
7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, Ite Medical Examiner must be natified at

death

72 hours after

filed within 7

be

permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun

requires that the death certificate be executed

Box 68760.

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attending physician

the

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icate has I ; page 2 s

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

altimore, Maryland 21215-0036

31. Date filed (Month, Day,

29b. Signature and title of certifier

2225E Defense Hwy, Crofton, MD 21114 32. Registrar's Signature

on who completed use of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

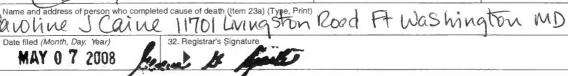
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State Registrar

MAY 0 7 2008

29b. Signature and title

31. Date filed (Month, Day, Year)



29c. License number

52741

29d. Date Signed (Month, Day, Year)

Samu 687 Records, Vital o

/Medical Examiner sician and burial-transit the ę ast attending p ed by the a detached f signed I this certificate director, funeral After t Division or Attending death. 4 hours after death. the filled in by To the Hospital within 24 hours a To the Funeral C

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

29a. Certifier

MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f charmany injury or other traumatic event.

Physician

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) MAY 0 7 2008

Farel

29b. Signature and title of certifier

Parastoo

St. Agnes Hospital, 900 S. caton Ave, Baltimore, mo 21229 Fazeli, MO, 32. P gistrar's Signature

- , MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

OP19513

29d. Date signed (Month, Day, Year)

May 5, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2203 M John Thomas Petrovich May 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Easton Ta1607 Hospita Memoria If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7 – 15 – 1957 Birthplace (State or Foreign Country) Age (In vrs. last birthday) Funeral Months Days 1 XM 2 □ F Hours Min. 222-50-9083 50 Delaware Director Usual Residence of Decedent r 28a-f show notified at 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2X No Director Talbot Neavitt Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ns 23a or 2 must be n 21652 USA 6375 Thamert Road Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or items the Medical Examiner m 11. Marital Status 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Site development Construction worker 12 injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) I and 2 should be fiillealth and Mental H m 27 is marked oth Be Marv Palir Theodore Petrovich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 S. Mechanic St. Wyoming, DE 19934 Mary Petrovich/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State of . 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Barratt's Chapel 5-16-2008 Frederica, DE 22. Name and Address of Facility Pippin Funeral Home, Inc. Signature of Funeral Service Licensee 119 W. Camden-Wyoming Ave. Wyoming DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 42 /Medical obstructive Pulmanary Sugar Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate 2 X No To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖼 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To funeral (27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Ecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 9951136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ynwood Dr. EASton MD Jorg M.D Abrea strar's Signature State 1 2 2008 Registrar

KN DHMH 17 Rev 1/2001

John Petrovich

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Vear 2008 Ma 11:40 PM George Edward Powell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Har ford Beldir Health and Rehabilitation Certa Bel 6. Sex 1 M 2 ☐ F 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 212-30-4709 76 09/22/1931 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Harford Haure de Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a 834 Linden Lane Funeral 21078 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Armed Folces.

1 Myes 2 Mo
If Yes, Give
Year or Dates: 1951-55 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No þ 3 Nidowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. the Systems Technician Communications item 27 Is marked other other traumatic event ** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Lewis Powell Mary Rebecca Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan E. Passwaters (daughter) 816 Linden Lane, Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Important: If ite
any Injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wesleyan Chapel Ceme. 05/10/2008 Aberdeen. Maruland 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Funeral Service Washington St., Havre de Grace, MD 123 S. 23a. Part1. Enter the disease, o shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical as a consequence Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical as ed by the attending detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho 24a. Was an s certificate has b lirector, page 2 s autopsy perform Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes Other: 2 N 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann f Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 🗌 Yes 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Manue

31. Date filed (Month, Day

Division or Vital Records, P.O. Box 68760,

		Plea	ase Type or P								gible.		
		For State Registrar	State of I	Maryland		oartment e <i>rtificate</i>		lealth and Death	Mental Hy	/giene 2 Reg. No.	008	16442	
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/Medic	cal	JOHN W. PAL		arl .		4h City 7	Town o	r Location of Deat	MAY		008 unty of Death	9:20 PM	
Examin	ier	4a. Facility Name (If not institution 111 GLENDALE A		er)		,		REVILLE	ın		EEN AN	NE	
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. la				If Under 24 Hrs Hours Min.		irth		place (State or Foreign	
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yland now at		10a. State 10b. County	у	10c. City,	Town or I	Location						10d. Inside City Limits	
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d with side with	Com	7	-0-	51 5+)]	FARMER				FAR	MING		
eve eve	Be	17. Father's Name (First, Middle						18. Mother's Na	me (First, Middle JONES	e, Maiden Sur	name)		
oral ylailor 2.12. 12 should be filed within h and Mental Hygiene. 7 is marked other than iraumatic event, the Me	유	HARVEY GRAHAM 19a, Informant's Name/Relation:			19b. Ma	iling Address	(Street	and Number or R		ber. Citv or To	wn. State. Zii	o Code)	
and alt		BENJAMIN PALM	MATARY/ NEPH	ŒW				AVE., CE				,	
00		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from Sta	te ce	metery, ci	position (Namer ematory or of	ther plac		Date		on - City or T	, and the second second	
ury and		4 □ Donation 5 □ Other (Specify)	СНО		HILL CI			-6–2008	CHURC	H HILL	, MD	
permit. Departi		21. Signature of Funeral Service	e Licensee	7//	FI	22. Name and ELLOWS	, HEL	FENBEIN RTY ST.,	& NEWNA	M FUNE	RAL HO	ME, P.A.	
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Physician		Immediate Cause (Final disease or condition	a 2ND	50A	16/2	ALi	24	EDW 026	25 1) IS EA	3E	Onset and Death	
/Medical Examiner		resulting in death)	Due to (or	as a consequ	ence of):								
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Physician: The rthis certificate	Be (25. Was case referred to medica examiner?							ath (Check only				
Phys ral din	-T	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inp.		R/Outpati 28b. Time	ent 3 DO		4 Nursing i	Home 5 ₽ Res	sidence 6 D		fy)	
Attending Ph r death. ector: After th by the funeral	ation	1 Natural 5 ☐ Pendi		Day Year)	Injury	м	8c. Injur Wor 1 □	ḱ? Yes 2 ⊟No		non injury oc	,50,1.00		
r Atte ter deg irecto	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	mined 28e. Place UI	injury - At hor , etc. (Specify)	ne, farm, s	street, factory	, office		28f. Location City or To	(Street and Nown, State)	umber or Run	al Route Number,	
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To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the f	Medical	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ing Physician: To the be I Examiner: On the basi and manner	s of examinati	on and/or	investigation,	in my o	me, date and place opinion, death occ	e, and due to the curred at the time	e cause(s) and e, date and pla	d manner as s ace, and due t	stated. to the cause(s)	
To the within To the complete	Me	29b. Signature and title of certific	er A	1		29c	Licens	e number		29d. Date si	gned (Month,	Day, Year)	
10%		2 ict.	(his me	K		D	35	1048)	5	5/0	8	
יון י		30. Name and address of person ERIC F. CIGANI					Ε, (CENTREVI	LLE, MD	21617			
Sta Registr		31. Date filed (Month, Day, Year MAY 0 5	7) 32 Reg	istrar's Signatu	ıre								
riogisti			- Julie	- JU	M								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician 38 30 2008 Patricia Pendergast P^{M} 1:15 /Medical Ann 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 440 Jefferson St. Apt. A Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 👿 F Yrs. Director 213-42-9105 64 North Carolina March 4,1944 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at 1 ☑ Yes 2 ☐ No must be notified Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5 440 Jefferson St. Apt. A items 23a 21740 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White þ 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CLA ARC of Washington Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Presley Myrtle Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kimberly Shoop/Daughter 809 Salem Ave., Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) injury Rest Haven Cemetery 5/2/2008 Hagerstown, MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licenses 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician carc disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examine the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months' Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 ☐No ed by the 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy 1□ Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)

certificate P this Certification:

Baltimore, Maryland 21215-0036

after death | Director: / d in by the f death

Division or Vital Records, P.O. Box 68760, Attending Physician: 0 To the Hospital o within 24 hours aff To the Funeral Di completely filled in

OH-1

DHIVIH 17 Rev 1/2001

State Registrar

Medical

31. Date filed (Month, Day, Year) 2003

2 No

29b. Signature and title of certifier

den

5 ☐ Pending investigation

6 ☐ Could not be

determined

1 🗌 Yes

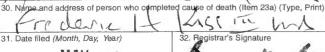
27. Man of Death

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide



Hospital:

1 Inpatient

28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

lin

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Yes 2 No

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Maryland / Department of Health and Mental Hygiene

Amend Item 26 per dr., 880, 06/27/08dbb

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Cathben 015 AM Petne 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles 15690 Cloverleaf Court Hughesvile If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

DC 8. Date of Birth (Month, Day, Year) 08/01/1935 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 🗓 F Yrs. Director 72 578-46-5977 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Sussex Bethany Beach DE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19930 U.S.A. 33324 Walston Walk Court Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home iges 1 and 2 should be filed to the of Health and Mental Hygie if item 27 Is marked other the other in the ot 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Lancaster Lawrence Fitzgerald ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33324 Walston Walk Court, Bethany Beach DE 19930 James M. Petrie/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If iter any injury or otl 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Southern Memorial Gds 05/06/2008 Dunkirk, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral HOme Calvert, P.A. Lisa M Mounte 8125 Southern MD Blvd. Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** o months disease or condition resulting in death) Crance /Medical Due to (or as a c equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed and burial-tran Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) o the 9 Unknown 9 ☐ Unknown signed by ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy
performed?

1 Yes 2 No certificate Vita 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nother (Specify) Residence Temporary 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 2 Division or this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the Funeral Director: upletely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours 29a. Certifier 🗜 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0 8 car 30. Name and address of derson who completed cause of death (Item 23a) (Type, Print) Bestgare Rd Site 300 Amaplio MD 200 20

State Registrar 31. Date filed (Month, Day, Year)

MAY

32. Registra Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Kimberly Dawn Rac		For State	Si	ate of N	Maryla	nd / D	epar	tment of ificate of	Health	n and	Menta	al Hyg		n Ne	20	0 8	3 1544
	R	egistrar . Decedent's Name	(First Midd	le Last)			COTT	incate or	Death			2.	Date of De	Reg. <u>No</u> ath		3.	Time of Death
Physician/ Medical Examiner		KIMBERI			A							1	Month May 4, 2		Year		0110 hrs
A 2	4	a. Facility Name (if		-		nber)		- 1	b. City, To Chest		ocation of	Death			c. County of De Queen Anne		
*	5	. Social Security N		6. Sex		7. Age (In	yrs. las	st birthday)	If Unde		If Under	24Hrs.	B. Date of E	Birth(MM	VDD/YYYY) 9.	Birthp	ace (State or
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Meralal Hygeria. Important: If tiem 27 is marked other than "natural", injury or other traumatic event, the <u>Medical Examiner</u> To Be Completed by I		17. Father's Name WILLIAN			ELHOU	ISE							NNAMOI		or Sumario,		
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Bal permi Depa Impo	¥	120	M.		10	Z	_	<u> </u>	B SOU	TH I	LIBER	TY S	TREET	CEN	TREVILI	E,l	ID 21617
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Division of Vital Records, P. ration Attending Physician: The law requires the rather death. Al Director: After this certificate has been signe eld in by the funeral director, page 2 should be desired in the completed in the state of the completed in the state of the completed in the state of the state		27. Manner of Dea		ending	May 4,	e of Injury th Day Yea 2008	ır)	0057 hrs	прогу	_	Yes 2 ✓	_ 16	asseng	er of r	notorcycle i	nvolv	ed in collision
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DHMH 17 Rev 1/2001

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State

Registrar

31. Date filed (Month, Day,

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2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 7:06 P Lucille Cerino Ring April 26 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Petomac Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 6. Sex Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F **Director** 046-32-7966 11/23/1941 Connecticut 66 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director CTNew Haven Branford 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 49 Jerimoth Drive 06408 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No White Specify: Completed by 3 ☐ Widowed 4 No Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Systems Technician AT&T Communication 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Cerino Ann Cassidy ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Ring - Son 4221 Brookfield Drive, Kensington, Maryland 20895 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery 05/01/2008 Westbrook, CT 21. Si natura of Funeral 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC. aguta 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Engr the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ossible Sepsis /Medical Due to (or s a consequence of): Examiner ancerh Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Physiclan: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death Day 5 ☐ Other (specify) 9 Unknown À Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probabiy 4 🕱 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 3 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation Natural 2 Accident 1 Yes 2 No thours after death. filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the ...
Within 24 hours ...
To the Funeral Di riscontifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bhogaville 9801 Georgia Avenu # 1-17 Silverspring Mn20902 Sun tha

State Registrar

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 19hy 5 4:00 F M ALICE UTH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Brooke Grove Nursing Home Olney If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 8/27/1921 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1□M 2፟MF Pennsylvania 142-14-1121 Yrs 86 Director Usual Residence of Decedent with the Marylend 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itama 23a or 28a-f ahow the Medical Examiner must be notified at Silver Spring 1 ☐ Yes 2 ☐ No MD Montgomery Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20906 USA 3194 Adderley Court death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ Specify: 3℃ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othe any injury or other traumatic avant, gloca. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alice Keppler George Koehler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard L.Roe/Executor-Son 12529 Montclair Dr.Silver Spring, Md. 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal 🕍 🦈 State 5/05/2008 Beltsville, Md. Chesapeake Crem 4 Donation Other (Specify) 21. Signature of Pyneral Se PHITTIP ACTOS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. En er the discussions, or leart furure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular disease Physician vears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed Hypothyroidism 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? this certificate 1 Yes 2K No 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4₺ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 은 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No i Diractor: A 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funeral 1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 5,2008 D43202

Registrar DHMH 17 Rev 1/2001

State

Division of Vital Records, P.O. Box 68760

ORIGINAL

3305 N.Leisure World Blvd.Silver Spring

Md.20906

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charlene Ozanne-Blankfard M.D.

32 Registrar's Signature

31. Date filed (Month, Day, Year)

MAY 0 6 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			1 - Registrar Certificate of Death		Reg. No.	3 16449							
	Physicia	an.	1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ath Day Yea	3. Time of Death							
	/Medic		Pierre Stevens	05	02 200								
A.E.	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death University of Mary and Medical Center Baltimore		4c. County of De	mose							
	Funeral		5. Social Security Number 6. Sey 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt	th 9. E	Birthplace (State or Foreign							
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Baltimore,	- C		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	4							
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п		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
	Physician		Immediate Cause (Final disease or condition Basal Ganalia Stoke			Onset and Death							
	/Medical Examiner		Due to (or as a consequence of										
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):										
	cuted id	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evenits c										
Ö,	e exe		resulting in death) Last Due to (or as a consequence of):										
68760	tificate be executed g physician and as the burial-transit	edical	d										
Box			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy		23d. Date of	delivery							
	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Physician/N	in the past 12 months? 1 \[\text{Live birth} \ 2 \] Fetal death \\ 1 \[\text{Live birth} \ 2 \] Foldard at time of death \\ 0 \[\text{Uth to sum} \ 1 \] O \[\text{Uth to sum} \ 1 \]		Month	Day Year							
P.0	at the de I by the a etached	Phys	9 Unknown 9 Unknown	oo- Dil		. A. M							
က်	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Diabetes			e to the cause of death? Probably 4 □Unknown							
Vital Records,	v requ	Completed by	11900	24a. Was		autopsy findings available							
Ř	rsician: The law s certificate has t lirector, page 2 s	duc		autoj	psy prior ormed? death	to completion of cause of							
<u>a</u>		Be C	25. Was case referred to medical 26. Place of Dea	th (Check only o	2 □ No 1 □ Y one)	es 212 NO							
	Physic this ce al direc	To E		ome 5□Resi	dence 6 DOther (S	pecify)							
Z C	ding P h. After 1 funera		27. Manner of Death 1 Natural 5 ☐ Pending (Month, Day Year) 28b. Time of Injury Work? 27 Accident investigation M	28d. Describe	how injury occurred								
Division or	Attend death death ctor: y the	ficat	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office			Rural Route Number,							
	s after al Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or To	wn, State)								
	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check only Check only C										
	thin 2.	Medical	one) and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Me								
	F 3 F 8	_	Kint M More ND P21127		5/2/2								
•			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
			Kristi M. Moore 22 S. Greene St Balfir	nore in	D 212	201							
	Sta Registr		31. Date filed (Month, Day, Year) NAY 1 3 2008										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 2008 1230PM LEROY SWOPE 02 MOND 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) WASHING TON 40SPITAL 4HGEKSTOWN WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth Worths Days Hours Min. 8. Date of Birth Worth Day, Year) 11/1937 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months 1**X** M 2 ☐ F PA 70 161-32-4428 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Tyes 2X No Mercersburg Franklin 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17236 USA 8534 Buchanan Trail West 12. Was Decedent Ever in U.S. Armed Forces? 1★1 Yes 2 □ No If Yes, Give Year or Dates: 1957 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) during most of working Crane Elementary/Secondary (0-12) College (1-4or 5+) Welder Manufacturer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Esther Catherine Cordell William Ambrose Swope 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8534 Buchanan Trail West, Mercersburg, PA 17236 Barbara A. Swope/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition May 6,2008 Mercersburg, PA 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Fairview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lininger-Fries Funeral Home Inc. 21. Signature of Funeral Service Licensee 47 N. Park Ave., Mercersburg, PA Tues 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Acure R resulting in death) Due to (or as a consequence of) ER ROS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Uu 40 Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Fctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 2 1 No 1 ☐ Yes 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) t⊟Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

2

Funeral

Director

ed other then "natural", or items 23e or 28e-f show event, the Madical Exerciper sust by notified at

if Health and Mental Hygiene. item 27 is marked other then other treumatic event, It e M.

permit. Pages 1 Department of H Importent: If ite any injury or ot

Pages 1 and 2 should be f nent of Health and Mental I

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Iner burial-transit Exam and physician as the use for ned by the a signed I d be det page 2 s has certificate funeral director. Be 2 this Certification: After

The law requires that the death certificate be executed

Physician:

or Attending

Division of Vital Records, P.O. Box 68760,

Completed by Physiclan/Medical

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 Thomicide

31. Date filed (Month

29b. Signature and title of certifier

1 ANatural

5 Pending investigation

6 Could not be determined

death. Director: , in by the f Direc

within 24 hours aft To the Funerel Di completely filled in the Hospitel To the within 2

State Registrar

Medical

MOHAMMEY AZIZ D66892 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMME

32. Registrar's Signature

2008

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

29c. License number 29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28b. Time of

Injury

251 EAST ANTIETAM ST., HAGERSTOWN, AD 21740

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month MAY Year **Physician** 2 2008 11:00A BARBARA SMITH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth (Month, Day, Y Nov 25, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Year) 938 **Funeral** 1 □ M 2 🗑 F Illinois 523-52-7293 69 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Director Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21702 6790 Ruhland Drive USA Pages 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23s. Iry or other traumatic event, the Medical Examiner must. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor State Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Hartshorne Mary Warner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kristen M. Moser/Daughter 6790 Ruhland Drive, Frederick, MD 21702 20a. Method of Disposition
1 ☐ Burial ZECremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 5/5/2008 Frederick,MD 21702 Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service 1621 Opossumtown Pike, Frederick, MD 21702 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pandio Immediate Cause (Final Physician disease or condition resulting in death) pulmonon /Medical Examiner eachlobath if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and "completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2☐ No 2 ER/Outpatient 3 DOA Inpatient 은 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064910 5-3-2008

DHMH 17 Rev 1/2001

State

Registrar

0

Frederick, MD 21701

4000 W. Seventh Street

32. Rajistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 6 2008

Pratima Pandy

31. Date filed (Month, Pay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 2008 1900 April 26, Silberstein /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) Montgomery Shady Grove Adventist Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months 1 □ M 2 X F 97 March 11, 1911 Poland Director 127-30-8033 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Flushing New York Queens 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 41-10 Browne Street, #3U 11355 S. U by Funeral - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give X 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: White 3 ₩ Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Silberstein, 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be one to the Mental Samuel Gutman Rachel Zucker ဥ or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau once. Sour Cherry Court, Darnestown, Maryland 20878 Samuel Silberstein - Son 20b. Place of Disposition (Name of cemetery organizery or other place)
Garden Of Remembrance
Memorial Park 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 4-29-2008 Clarksburg, Maryland 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 20852 21. Siuna of Funeral Sacrice Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Respiratory Failure /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2X No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Acute Renal Failure Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2√ No 24a. Was an s certificate has b lirector, page 2 s autopsy 1☐ Yes 2 X No director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 1X Inpatient 2 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death after death.
I Director: After to d in by the funera Certification: (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide

To the Hospital o within 24 hours aft To the Funeral Di completely filled in

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 2, 2008

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Brian Carpenter, M. D. 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Minor Stewart John 2008 2:10 A May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Casey House - Montgomery County Rockville Montgomery ROCKVILLE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Jan. 13, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ▼ M 2 □ F Yrs. 1924 New Jersey 84 Director 146-16-9343 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he national once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Director Montgomery Village MDMontgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20886 United States 19310 Club House Road #516 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married WW II 1 ☐ Yes 2 No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Technical Writer <u>Aerospace</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Minor Stewart, Sr. Margaret Voorhis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 19a. Informant's Name/Relationship (Type. Print) 19900 Collingdale Place, Montgomery Village, MD Elizabeth Tinling / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-5-2008 | Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
DeVol Funeral Home, 10 East Deer Park Drive,
Gaithersburg, MD 20077 ature of Funeral Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory at est, shock, or heart failure. List only one cause on each line. Immediate Cause (Final mt Physician Subdural Hematoma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Fall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Congestive Heart Failure 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Chronic Obstructive Pulmonary Disease 24a. Was an autopsy performed? res 2 🗓 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ${}_{4\square\,\text{Nursing Home}}$ ${}_{5\square\,\text{Residence}}$ 6 \boxtimes Other (Specify) Hospice 1 X Yes 2 ☐ No 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work?

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: Af

Baltimore, Maryland 21215-0036

Certification: To Medical

5 Pending investigation 1 Natural April 13,2008 1700 1 ☐ Yes 2 X No Fall at Residence 2 X Accident Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 19310 Club House KI determined 4 Homicide #516, Montomgery Village, MD Residence Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Fxaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sidnatui D0064615 May 3, 2008 cli and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Wroblewski, M.D., 1355 Piccard Drive, Suite 100, Rockville, MD 20850 31. Date filed (Month, Day, Year) State

MAY 0 6 2008

32 Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar		Sta	ate of M	Marylan		rtment of F		d Mental I	Hygier Reg. 1	2.0	08	Andrewson .	1.54
Dhysisis		1. Decedent's Nan	ne (First, Middle	Last)						2. Date o		Day	Year	3. Time o	f Death
Physicia /Medic		David	Ca1dwe				Su	tton		Apri]		2008		7:45	P M
Examine	er	4a. Facility Name (•	_	4b. City, Town, o			4	4c. County o	f Death		
· · · · · · · · · · · · · · · · · · ·		Montgom 5. Social Security I		lage I 6. Sex		n Care Age (In yrs. I		r Montgo	omery V	Hrs. 8 Date o	f Rirth	Montgo		y lace (State	or Foreign
Funeral Director		140-20-		1 X M 2		81	Yrs.	Months Days		Ain. (Month	4, Day, Yea	ar)	Coun	sachus	
pu ,		Usual Residence of	of Decedent							1					
shov shov	ō	10a. State	10b. County				y, Town or Loc						31	0d. Inside C 1 ☒ Yes	2∏No
the N 28a-f notifie	Director	MD 10e. Street and Nu	Montgo	mery		Mon	tgomer	y Village	e		10a. (Citizen of Wh	hat Coun	itry?	
3a or		19301 W		Mill H	Road			20886				S.A.		,.	
death	Funeral	11. Marital Status		12. W		nt Ever in U.	S. 13. V	vas Decedent of F Yes, specify Cub	lispanic Origin?	? (Specify Yes o	r No-	14. Race			
after or ite			ried 2 Marri	ed 1	☐ Yes 2 F Yes, Give	⊠ No		☐Yes 2⊠No	Specify:	uerto i neari, etc.	•)	Specify:	, White,		
hours tural*	ed by	3 Widowed	4 Divorced		ear or Date:	s:	16a Deced	ent's Usual Occup	nation		16h	Kind of Bus	Whi		
n "na n "na Medic	Completed		cify only highes	t grade com	pleted)		(Give I	kind of work done O NOT use retire	during most of d)	working	100.	Killa of Bas	111625/1110	lustry	
d with giene er tha	mo.	Elementary/Sec	ondary (0-12)		ollege (1-4d 5+	or 5+)	Admin:	istrator			На	.1f Way	у Но	uses	
be file tal Hy d othe	Be	17. Father's Name	(First, Middle, I	_ast)					18. Mother's I	Name (First, Mic	ddle, Maid	en Surname)	,	. –
Ment Ment Markec	ို	Lewis S					1			Caldwe					
12 sh h and 7 is m traum		19a. Informant's N			·		1.	g Address (Street					State, Zip	Code)	
1 and Healt tem 2	1	Joan D. 20a. Method of Dis		- Ex-	-wire	20b. P	lace of Dispos	erra Cou	i	ckville Date		20850 Location - C	ity or To	wn. State	
ages ent of it: if it		1 🛮 Burial 2	☐Cremation 5 ☐ Other (Sp		al from Sta	te C	emetery, crem	eaven Cer		2/2008	Si	lver			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ı	21. Signature of F				Juac		Name and Addre				ing, M			
lo a ji pe		Dona	ld C.	Sto	ttler	nede	_ Da:	nzansky- 70 Rockv:	Goldber ille Pi	g Memor ke Roc	tai (kvill	nape⊥ .e, MD	208	nc. 52	
7.5°		23a. Part1. Enter shock, or he	the disease, or art failure. List	complication	ns that caus	sed the death	. Do not ente	r the mode of dyir	ng, such as care	diac or respirato	ory arrest,			Approxima Interval Be	tween
Physician		Immediate Cause disease or condition resulting in death)	(Final				mbolis							Onset and Month	
/Medical Examiner		resulting in death)				as a consequ	· ·								
₩ .0	<u>-</u>	Sequentially list co	onditions,	D		ein Th	rombos	is						Month	s
uted d ansit	Examiner	cause. Enter Und Cause (Disease of that initiated event	r injury	A	trial	Fibr	illatio	n					,	Months	2
ate be executed hysician and he burial-transit		resulting in death)				as a consequ								10110111	
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ica			d	Schize	phren	ia							Years	
leath certifical attending phy for use as th	Physician/Med	IF FEMALE:		00e If	una autoam	no nf nasana									
attend for us	cian	23b. Was deceder in the past 12	2 months?	11	Live birth	ne pf pregna 1 2 □ Fetal 1 at time of de	I death 3□	Ectopic pregnancy Other (specify)	/			23d. Date Mont		-	Year
at the de by the a stached	ysic	1 □ Yes 2 9 □ Unknow			Unknowr		00.11	Outer (specify)							
s that	by P	Part II. Other sign	ificant conditio	ns contribut	ing to death	but not resu	alting in the un	derlying cause giv	en in Part I.	23e. I	Did tobacc	o use contrit	bute to th	e cause of	death?
w requires that s been signed to should be deta	ed	Dementi	a							_ 1	I □ Yes	2 □ No 3	3 ☐ Prob	ably 4 🔣	Unknown
has be	Completed										Vas an	24b. W	ere autor	psy findings	available cause of
	5										performed:	? I de	eath? □Yes	-	
70 0 2	Be	25. Was case refe examiner?		Hospita	al:			3 DOA Oth	or:	Death (Check o					
Physer this eral di	<u>۵</u>	1 ☐ Yes 2 ☑ 27. Manner of Dea			a. Date of I	njury	ER/Outpatient 28b. Time of	28c. Injur	v at	g Home 5 ☐ F		6 ☐Other)	
ath. r: After re funer	Certification:	1 X Natural 2	5 ☐ Pending investig	ation	(Month, I	Day Year)	Injury	M 1	k? Yes 2∐No			,			
r Atte er dea irecto		3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi		e. Place of i	injury - At hor etc. (Specify	me, farm, stre	et, factory, office			on (Street r Town, Sta	and Number	r or Rura	l Route Nur	nber,
ital o	င်														
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical	29a. Certifier (Check only one)	1 X Certifying 2 Medical E	xaminer: C	: To the be on the basis nd manner	of examinat	wledge, death tion and/or inv	occurred at the tire estigation, in my o	me, date and pl ppinion, death o	lace, and due to occurred at the t	the cause ime, date a	(s) and man and place, ar	ner as st	ated. the cause(s)
To the To the Comp	ž	29b. Signature and		0 1	9			29c. Licens	0		29d. [Date signed	(Month, I	Day, Year)	
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	-	30. Name and add		-				rint) erick Ave	nuo #/-	13 Cod+1	narah	ura l	ΔD 20	1877	
Stat	e	31. Date filed (Mor	nth. Dav. Year)			strar's Signat		LICK AVE	.nue #4.	ı) Gallı	TELSD	urg, P	עב עני		
Registra	-		MAY 0 6	2008	Ben	euro d		20/21							
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Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. \angle 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Somervi 0030 M 30 2008 04 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NUISING St. MARUS CENTERIN St. MAR LEONARDEOWN 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 1□M 2☑F 213-46-Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nnent of Health and Mental Hygiene. and the them 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "mate be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10g, Citizen of What Country? St. Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private omemakek High Schoo 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sam Waters ပ Genevieve Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Somerville/Grand-daughter P.O. Box 241 Loveville, MD 20656 e of Disposition (Name of Date 20c. Lov 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If 4 Donation 5 ☐ Other (Specify) Sacred Heart Cemetery 5/7/2008 Bushwood, MD 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Funeral Service Lig 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in hi art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, in any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 @ No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title

31. Date filed (Month

MAY 0 7

P.

certifier

Jarboe

2801

ause of death (Item 23a) (Type, Print

Péabody Street

29c. License number

Leonardtown, Maryland 20650

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Francois 2240 Dout /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner DEECO Joris Bout 17EUD 10tigral (PITES If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 1934 Haiti 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Apr. 11 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1**X** M 2 □ F 267-93-5886 74 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show MD Caroline Federalsburg 1 TYYes 2 No Direct the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21632 316 East Central Avenue United States Funeral 7 is marked other than "natural", or itams traumatic event, the Medical Examiner man 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritaf Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 XNo Specify. Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Poultry Line Worker 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be nd Mental Saul Francois Souil Silvana Silvain 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 E. Central Ave., Federalsburg, MD 21632 Germaine C. Souil/Spouse f Health other 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State or other place) ō 1

Burial 2 □ Cremation 3 □ Removal from State pernit. Page Department of Important: If any njury or pnce. Federal Hill Cemetery 05/18/08 Federalsburg, Maryland ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Eskar Muhael 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** TTACK (CONOL END DILEDZE /Medical Due to (or as a consequence of): Examiner 1 POTETRS S quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit law requires that the death certificate be executed 1/20 JENJBU Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a o. 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 1 No 1 Yes of Vital 1 ☐ Yes 2 ☑ No Physician: Be 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 1€ No Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Division 1 Natural 5 Pending 1 □ Yes 2 □ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) In by 4 Homicide filled the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the Fune completely f (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 0 on milled 0 00 27527 5-12-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (TCHAPT 14. M.D. MOD Hospital Contactoristones mo glason JCHLOTTMAN 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAY 1 4 2008

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Registrar

ORIGINAL

SPB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 27 Pay 2008 ear **Physician** Rose S. Trice 9:10 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Ruxton Health of Denton Denton If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Feb 12 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Days Maryland 86 216-09-7790 1922 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 □Yes 2X No , or Items 23a or 28a-f sh aminer must be notified Director Caroline Greensboro Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21639 U.S.A. 25465 Linhard Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: þ 3 XWidowed 4 ☐ Divorced White 'natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress clothing manufacturing marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elsie Jones Kibler August P. Kibler ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Rose M. Bowman/ daughter 25465 Linhard Lane; Greensboro, Maryland 21639 Department of Health Important: If Item 27 any injury or other trong once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Holy Cross Cemetery | May 1 2008 Greensboro, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA PO Box 160; Greensboro, Maryland 21639 21. Signature of Muneral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Livers Due to (or as a consequence of): Sequentially list conditions burial-trar ed by t

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner within 24 hours after death

To the Funeral Director:
completely filled in by the

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): C. Due to (or as a consequence of): d.	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 → 10 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 □ ▼No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ◯ No		th (Check only one) ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	ysician: To the best of my knowledge, death occurred at the time, date and place niner: On the basis of examination and/or investigation, in my opinion, death occu- and manner stated.	

29c. License number

State Registrar

29b. Signature and title of certifier



29d. Date signed (Month, Day, Year) 4-28-08

AMEND ITEM 26, QACHD, PER DR, 5-6-08, MS epartment of Health and Mental Hygiene = For A State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 7:00 AM 2008 ANGELA GOEHRING TAYLOR MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner QUEEN ANNE'S 400 SAWMILL LANE **GRASONVILLE** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 X F 35 JULY 10, 1972 MARYLAND Director 214-76-0198 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County raf", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 📉 No Directo GRASONVILLE MARYLAND QUEEN ANNE'S 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 400 SAWMILL LANE 21638 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. should be filed within 72 hours after on Mental Hygiene.

s marked other than "natural", or ite 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ▼ Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify. þ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be f Health and Ments item 27 Is marked BARBARA DENNIS ARTHUR WILLIAM GOEHRING 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 400 SAWMILL LANE, GRASONVILLE, MARYLAND 21638 TORY TAYLOR, SR./HUSBAND other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If it MAY 6 9 STEVENSVILLE CEMETERY injury STEVENSVILLE, MARYLAND 2008 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 21. Signature of Funeral Service Licensee any nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in each line, Approximate Interval Between Onset and Death 23a. Part1. Enter the shock, or heart e, or complications List only one caus Multiforme Immediate Cause (Fina Glousstoma month **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner grade Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician requires that the death certificate be Physician/Medical the use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 1∐ Yes 2 No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2**S**TER/Outpatient 3 □ DOA 5 Residence 6 □Other (Specify) Certification: To After this funeral 27. Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 ☐ Homicide To the Hospital within 24 hours a 1 🗲 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064099 MO 30. Name an address of person who completed crus e of death (Item 23a) (Type, Print) 21231 Blateley MO JOHNS HOLLINS BALTIMORE, MARYCAND UNIVERSITY 1550 ORCEANS ST. SUITEIMIG gistrar's Signature State 6 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2008 Year Charles Ear1 Tribbett 2 5:50 A M May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 501 Beaver Dam Lane Ingleside Queen Anne If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1XM 2□F 216-40-2549 Maryland 66 June 4 1941 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Queen Anne Ingleside 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 Beaver Dam Lane 21644 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) grain-Elementary/Secondary (0-12) College (1-4or 5+) residential/beef cattle carpenter/ farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harvey Franklin Tribbett Bessie Hester Hughes Tribbett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Tribbett / spouse 501 Beaver Dam Lane; Ingleside, MD 21644 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Cremation Ctr 5/3/08 4 ☐ Donation 5 ☐ Other (Specify) Chester, Md 21. Signature of Euneral Service Li Fleegle and Helfenbein Funeral Home, PA homas PO Box 160; Greensboro, MD 21639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic 0010 xis 2 mo Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Due to (or as a consequence of) or as a consequence of) come pf pregnancy pirth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Year ant at time of death 5 ☐ Other (specify)

Physician /Medical **Examiner**

physician

Department of Health Important: If item 27 any injury or other tr once.

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

the M

Baltimore, Maryland 21215-0036

Examine burial-transit Physician/Medical for use detached signed t 3 Completed Be Certification: To funeral o ne Hospital or Atı. hours afler death. 'n Director: Afler 'by the fur

The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

resulting in death) Last	Due to (or as a consequence of):
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)
Part il. Other significant conditio	ns contributing to death but not resulting in	the underlying cause given in Part I

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed?

0= 14/											
25. Was case referred to me examiner?	dical	26. Place of Death (Check only one)									
1 Yes 2 No	Hospita	ll: 1	☐ ER/Outpatient	Home 5 X Residence 6 □Other (Specify)							
Z LI Accident	ending vestigation	a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred					
	Could not be determined 28e. Place of injury building, etc. (Place of injury - At building, etc. (Spec	home, farm, stree	t, facto	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a Certifier 1 Cert	ifving Physician:	To the hest of my kr	nowledge death	occurre	ad at the time, date and place	and due to the enuse(a) and manner as stated					

(Check only one)	2 ☐ Medical
29b. Signature and	title of certifie

2 Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) D66270

30. Name and address of person who completed cause of death (Horn 23a) (Type, Print)

Halveson 8221 Teal DR Suite 302 Varid C. MD Eston, 21601 31. Date filed (Month, Day,

State Registrar



DHMH 17 Rev 1/2001

within 2. the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Frances Vanetta TAYLOR 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Hours 1 □ M 2 1 X 219-60-4698 68 Director Dec. 18, 1939 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f sh Examiner must be notifled 1 X Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 727 South Potomac Street 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 212 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify white Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) telephone operator 12 State of Maryland O permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, it 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Be Jeller B. Huyett Lottie Albert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald R. Taylor, Sr.- husband 727 South Potomac St., Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 5/7/08 Hagerstown, Maryland 21. Signature of Fuperal Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Ovarian Cances disease or condition resulting in death) 25 olan /Medical Examine Saquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): physician as the IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached the 9∏Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760, or Attending Physician:

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

and manner stated. 29b. Signature and title of certifier

29c. License number D53853

tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HABIB CHOTANI 251 E ANTIETAM STREET,

HAGERSTOWN, MD 21740

State Registrar

Medical

4 ☐ Homicide

29a. Certifier (Check only one)

ORIGINAL

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Ave.

Easton,

in

32. Registrar's Signature

MD

508

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sanchez

MAY 0 8 2008

Robert

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

08-03401 Isaias Lopez-Vail

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las Lopez-vai	1	- For State	Ce	ertificate of	Death		Reg. No.	3. Time of Death			
Physicia	an/		Decedent's Name (First, Middle, Last) Month								
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		1308 Merrimac Drive 5. Social Security Number		. last birthday)				9. Birthplace (State or Foreign			
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id how any tte.		Usual Residence of Decedent 10a. State 10b. Count MD Pril	nce George's	ty, Town or Location Hyatts\	ville		10g. Citizen of Wha	10d. Inside City Limits 1 Yes 2 X No			
Marylar r 28a-f s	Directo	10e. Street and Number	mac Drive #3		10f. Zip Code 20783			temala			
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. tent and Mental Hygiene. tent 27 is marked other than "naturalt", or items 23a or 28a-f show any tranumatic event, the Medical Examiner must be notified at once.	Funeral D	11. Marital Status 1 X Never Married 2	Married 12. Was Decedent Ever in Armed Forces? 1 Yes 2 Not Not Not Yes 1 Not Not Not Not Not Not Not Not Not Not	1 If Y	S Decedent of Hispanic Ces, specify Cuban, Mexice Yes 2 No spec	can, Puerto Rican, etc.)	No- 14. Race - White, Specify:	American Indian, Black, etc. White			
72 hours afte n "natural", al Examiner	eted by	15. Decedent's Education (S Elementary/Secondary (0-1	pecify only highest grade completed) 16a. Deceden during m	t's Usual Occupation (Gi ost of working life. DO N se Painte:	ive kind of work done OT use retired)	f work done 16b. Kind of Business/Industry				
21215-0036 muld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Completed	5 17. Father's Name (First, Midd		nou	18.Mot	ther's Name (First, Middl aria Dion	le, Maiden Surname)	l Perez			
21215 ould be fil d Mental F s marked tic event, j	To Be	19a. Informant's Name/Relation	Rufino Lopez onship (Type, Print)	19b. Mailin	- Address (Street and	Number or Rural Route	Number, City or Town	n, State, Zip Code)			
ore, MD Ses I and 2 shot of Health and If item 27 is ther traumatin		20a, Method of Disposition	pez/Brother	b. Place of Dispos	Merrinac sition (Name of cemetery ther place) tenango,	, Date	.#3 Hyattsville,Md 20 Date 200c. Location - City or Town, State Ouetzaltenance /10/2008 Guatemala				
Baltimore, permit. Pages I at Department of He Important: If ite	1	4 Donetion 5 Other 21. Sig a e of Funeral Serv	VICE, P.A. oring, Md20910								
Physiciar	1	23a. Part I. Enter the disease failure. List only one cal	e, or complications that caused the de use on each line.	eath. Do not enter	41 Columb the mode of dying, such	as cardiac or respiratory	arrest, shock, or hea	art Approximate Interval Between Onset and Death			
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	iner	Sequentially list conditions, if any, leading to immediate	b	ce of):							
urted Id	Examine	1	ed Due to (or as a consequen	ce of):							
760, icate be executed physician and the burial attances	Medical	UNPENDED	AMENDED				23d. Date o	f delivery			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici To the Funeral Director: After this certificate has been signed by the attending physici	Physician/Me		4 Pregnant at time	2 F	Fetal death 3 E	ctopic pregnancy	Month	Day Year			
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Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending To the Funeral Director: After this certificate by the conversal process.	Completed by						autopsy performed?	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
Rec The la	bage				26.Place of I	Death (Check only one)	Yes 2 No				
ital ician: s certi	B B	25. Was case referred to me examiner?	Hospital: 1 Inpatient	2 ER/Outpation	Oth	Nursing Home	5 Residence 6	Other: Scene			
n of V ding Phys h. : After thi	e funeral dir	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5	28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time FOUND: 0348 hrs	of Injury 28c. Injury at	2 ✓ No Subject	cribe how injury occu t beaten				
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director:	filled in by the fune	2 Accident 3 Suicide 6	Investigation Could not be determined May 4, 2008 28e. Place of Injury (Specify) Multi-f	- At home, farm, s	treet, factory, office build	T	ation (Street and Num lown, State) errimac Drive, Lari	nber or Rural Route Number, City gley Park, MD			
he Hospits in 24 hours	pletely fill		ing Physician: To the best of my kn		courred at the time, date a igation, in my opinion, de	and place, and due to the	ne cause(s) and manne, date and place, and	ner as stated. If due to the cause(s)			
To t	moo	(Check only 1 Certify one) 2 Medica 29b. Signature and title of o	and marmer stated.		29c. License n	umber	29d. Date si May 4, 2	gned (Month, Day, Year)			
			person who completed cause of deat	h (item 23a) er 111 Pen	n Street, Baltimore	e, MD 21201					
	Sta	Ana Rubio MD. 1e 31. Date filed (Month, Day,			aff 1						
Reg	gistr	ERRY A	6 2008 Reserve	13. 1470							
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			State of Maryland / Department of Health state Amend Item 29d per dr., g879,05,40,08dhb f Death Registrar	n and Me th	ntal Hy	giene Reg. No. 2	008	16463
	Physicia	an.	1. Decedent's Name (First, Middle, Last)	2	. Date of Dea	ath Day	Year	3. Time of Death
	/Medic		Dorothy E.C. Welch	M	lay 3,			5:05pm ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location	on of Death		4c. Count	y of Death	
	- come of the second		Wilson Health Care Center Gaithersbu 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under		. Date of Birt		tgome	ry place (State or Foreign
	Funeral Director		533-20-3660 1□ M 2X F 97 Yrs. Months Days Hours	rs Min.	(Month, Da	v, Year)	Cou	ington
	and www.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
	Maryl f sho led a	rot	Maryland Montgomery Gaithersburg					1X Yes 2 No
	the 128a-	Director	10e. Street and Number 10f. Zip Code			10g. Citizen of	What Cou	ntry?
	h with	al D	201 Russell Avenue 20877			Unite	d Sta	tes
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic C	Origin? (Speci	fy Yes or No-		ce - Ameri	can Indian,
õ	after or Its		1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give 1 □ Yes 2 ☒ No Specifi		oan, oto.,	Speci		eic.
2-0036	hours after death with the Maryland tural", or Items 23a or 28a-1 show al Examiner must be notified at	d by	3X Widowed 4 □ Divorced Year or Dates:				Whi	
ç	"nat	lete	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during molifie. DO NOT use retired)	nost of working		16b. Kind of E	susiness/In	dustry
717	withi iene. r thar the M	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Self Employed			Retail	Cosm	etics
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yland	uld be Venta rrked rflc ev	ToE	Edwin Christiansen Mol	11y Woo	dy			
Mary	2 sho and I Is me		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Num.	mber or Rural I	Route Numbe	er, City or Towr	, State, Zij	Code)
رب ح	and fealth m 27 her tr		Janet Jarvis (Friend) 426 Gun Road, Hal					
0	it of F		20a. Method of Disposition 1 ☐ Burial 2 【I Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Dat		20c. Location	- City or To	own, State
saltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (Specify) Metropolitan Cremator: 21. Signature of Juneral Service Licenses 22. Name and Address of Faci	y 5/5/0	08	Alexand	ria,	Virginia
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п			23a. Fart1. Enler the disease, or complications that/caused the death. Do not enter the mode of dying, such a shock or heart failure. List only one cause or each line.			rest,		Approximate
	Physician		Immediate Cause (Final					Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Colon Cancer Due to (or as a consequence of):					Years
	Examiner		Sequentially list conditions					
i z	D ##	iner	Sequentially list conditions, lf any, leading to immediate cause. Enter Underlying					
	and I-trans	Examiner	that initiated events c. Due to (or as a consequence of):				-	
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X D	death certifi e attending d for use as	N/	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. D	ate of deliv	ery
	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)			М	onth	Day Year
т 5	at the	Phys	9 LI ONKHOWN					
Ś.	requires that een signed b nould be deta	۾	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	art I.				he cause of death?
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Hecords,	The law i	Completed			24a. Was	an 24b. rmed?	Were auto prior to co death?	ppsy findings available mpletion of cause of
_	n: Th ficate r, pag		OF Was and referred to madical		1□ Yes	2 X No	1 Yes	2 No
5	Physiclan: this certific) Be	examiner: Hospital: Other	ace of Death (-			
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SION	Attending r death. ector: After by the fune	atio	2 Accident investigation M 1 Yes 2	□No				
Š	or Atte ter de Irecte n by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28	f. Location (S City or Tow	Street and Num n, State)	ber or Run	al Route Number,
ב	pital o							
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 of the property of the funeral director.	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date at 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of the control of the contr	e and place, an death occurred	d due to the	cause(s) and m date and place	anner as s , and due t	o the cause(s)
	To the Total	Σ	29b. Signature and title a certifier 29c. License number	er		29d. Date sign		
1	0		D20148			May 5,	2006	
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			000==		
	Sta	te.	Stephen Dolinsky, M.D. 911 Russell Avenue, Gaith 31 Date filed (Month, Day, Year) 32 Registrar's Signature	nersbur	g, MD	20877		
	Registr		MAY 0 6 2008 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					

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			For State Registrar	State of M	aryland		rtment of F tificate of I			giene Reg. No	2000	16464	
	Physici	an	1. Decedent's Name (First, Middle	e, Last)					2. Date of De Month	Da	y Year	3. Time of Death	
	/Medi		Lawrence Victo				·		May	2, 2	800	2:55 P M	
	Examir	ier	4a. Facility Name (If not institution	n, give street and number)			-	r Location of Death	1	4c. County of Death			
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		-24	Casey House 5. Social Security Number	6. Sex 7. An	je (In yrs. last	t hirthday)	Rockvill If Under 1 Year	If Under 24 Hrs.	8 Date of Bir		ntgomer	thplace (State or Foreign	
Ľ	Funeral Director		579-44-4324 Usual Residence of Decedent	6. Sex 7. Ag	74	,	Months Days	Hours Min.	8. Date of Bir (Month, Da Apr 17	y, Year) • 19	34 Was	hington, D.C	
	aryland show	7	10a. State 10b. County		10c. City, T							10d. Inside City Limits 1 ☐ Yes 2 No	
	the M	Director	MD Montgo 10e. Street and Number	mery	Silve	er Sp	ring 10f. Zip Code			10a Cit	tizen of What Co		
	23a or	ral Dir	3321 S. Leisure	World Blvd.	#98-1		20906			USA	The second secon	ountry:	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🕱 Divorced	If Yes, Give		ì	Vas Decedent of H f Yes, specify Cuba I □ Yes 🏖 No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)) -	14. Race - Ame Black, Whit Specify: Wh		
5-0	72 h "natu dical	etec	15. Deceden (Specify only highe	t's Education st grade completed)	1	6a. Deced (Give	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of wor	king	16b. K	ind of Business	/Industry	
121	within	Completed	Elementary/Secondary (0-12)	College (1-4or !			alesman	d)		A11#	omotive	Salas	
d 2	filed withii Hygiene. xther tha n ent, the M		17. Father's Name (First, Middle,	Last)		Jal D	aresman	18. Mother's Nam	ne (First, Middle			Dates	
an	id be ental ked c	To Be	Irving Zapol					Sonia			ŕ	(unk)	
Maryland	nd 2 should be filed w lith and Mental Hygie 27 Is marked other ti r traumatic event, th	-	19a Informant's Name/Relations Justin Zapol/so				ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philmont Drive #2 Gaithersburg, MD 20878						
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trat		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Date 3/08		ocation - City or						
Balti	permit. Departm Importar any Inju	21. Signature of Funeral Service Licensee Coing Home Cremation Ser MO1251Beverly L. Heckrotte, P.											
45			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused	the death. [Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	TKSVIII	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	_a. Metastat							1	Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as									
	p #	iner	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequen	ce of):							
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	2.000000000	on of):							
68760,	ificate be executed g physician and as the burial-transit	edical E	3 ,	d.	a consequen	——————————————————————————————————————							
	E 00 6		IF FEMALE:									1	
O. Box	the death certifi / the attending ched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3□	Ectopic pregnancy Other <i>(specify)</i>	/			23d. Date of de Month	livery Day Year	
Records, P.	requires that the de een signed by the a nould be detached i	by	Part II. Other significant condition	ons contributing to death b	ut not resultin	ng in the ur	nderlying cause giv	en in Part I.				the cause of death?	
CO	> 0 to	lete							24a. Was		24b. Were a	utopsy findings available	
al Re	The ate h page	Completed		. 1					auto perfo 1∐ Yes	psy ormed? 2124No	prior to death?	completion of cause of	
Vital		Be	25. Was case referred to medica examiner?	Hospital:		10 1 11	Oth	_26. Place of Dea er:					
o		5	1 Yes 2 No 27. Manner of Death	28a. Date of Inju		b. Time of	1 OLI DON	4 □ Nursing H	ome 5 ☐ Resi 28d. Describe			ecify) hospice	
ion	Attending Phrdeath. ector: After the system of the funeral	iţi	1XXNatural 5 ☐ Pendin 2 ☐ Accident investi		y Year)	Injury		ƙ? Yes 2∐No		•	•		
Division		Certification:	3 ☐ Suicide 6 ☐ Could of determined	inod 20e. Flace Utili]	ury - At home c. (Specify)	, farm, stre	eet, factory, office		28f. Location (City or To			ural Route Number,	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C		ng Physician: To the best Examiner: On the basis of and manner st	f examination								
	To the H within 24 To the F complete	Me	29b. Signature/and title of certifie	1/1/-	-/		29c. Licens	e number		29d. Da	ate signed (Mon	th, Day, Year)	
			Shenare	Wro le	USE	a	D64615	5		May	2, 200	8	
(3)	00		30. Name and address of person Genevieve Wrobl					L Rd. Roc	kville,	MD	20855		
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	-							
	Registi	ar	MAY 0	7 2008	word	K L	head						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 0255AM KEITH may 2008 Anderson 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltomore Randallstoner HOSPITA North west 5. Social Security Number 217-90-298 Usual Residence of Decedent If Under 1 Year | If Under 24 Hrs. 8. Date of Birth , (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Days Months Hours 1⊠M 2□F Yrs. 10d Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 XYes 2 No MARVLAND 10g. Citizen of What Country? 10e. Street and Number AVIFIELD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 💢 Married 1 ☐ Yes 2 X No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) THGRADE College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, MD. 21223 Date ST. BALTIHORE 20c. Location VALERIE ANDERSON (WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 15-27-08 EALTIHORE 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 2948 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosderote Coronary Vascular Disease Due to (or as a consequence of): nd State Cena Due to (or as a consequence of): Genal Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Uncontrolled ity pertension Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliven 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Immune Defluency 1 Yes 2 No 3 Probably 4 blnknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 → No Hepathis 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 100 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director.

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or iteme 23a or 28e-f ahow the Medical Exeminar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Institution of Health and Mental Hygiene any injury or other traumatic event. The Medical Ferritorials and Mental Hamiltonia Ferritorials.

Physician /Medical Director

Funeral

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6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and little of certified

29c. License number

29d. Date signed (Month, Day, Year)

D0057634

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

AD 540)
32. Registrar's Signature Court Rd Randallstown MD Christine Brand, MD

State Registrar 31. Date filed (Month, Day, Year) 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 31, perDVR, g879 5/21/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Robin Lee Albrecht /Medical May 18, 2008 8:22P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 823 North Woodlynn Road Baltimore Co. Essex 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 M MXXF Yrs. **Director** 216-82-5922 46 Dec. 19,1961 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at Be Completed by Funeral Director Maryland 1 ☐ Yes 2 🛱 No Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 823 North Woodlynn Road 21221 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ॲ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 100 Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be f nent of Health and Mental int: If Item 27 is marked o 2 Robert Lee Carter Betty Lee Undutch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) 823 North Woodlynn Road Essex Maryland 21221 Robert J. Albrecht Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If It t Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery | 5-22-2008 | Elkridge Maryland 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk Inc. 21. Signature of Funeral Service Licensee 7922 Wise Avenue Dundalk Maryland 21222 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metasta ~ 9 mon disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any cooling to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and the attending physiclan and ned for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Registrar DHMH 17 Rev 1/2001

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 401

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32. Registrar's Signatur

29b. Signature ar

Fathi

31. Date filed (Month, Day, Year)

Broadway,

29d. Date signed (Month, Day, Year)

D0065799 5/19 Baltimore, MD 2123L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) [™]05/20/2008 1:35 A M John Leroy Bruckart 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Carroll Westminster Golden Living Center If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Social Security Number Days onth, Day, Year) 11/23/1923 1 XM 2 ☐ F 84 203-10-6162 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2€No Sykesville Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21784 6310 Wild Lake Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 3 ☐ No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 → Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WCMB Radio Sales/Announcer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Minnie Palmer John L. Bruckart, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6310 Wild Lake Dr., Sykesville, MD 21784 Winifred Bruckart/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 5/20/08 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State South Carroll Crematory Winfield, MD 5 ☐ Other (Specify) 4 Dopa Funeral Service Licenses Burrier-Oueen Funeral Home & Crematory, P.A. 21. Signature of art1. Efter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1212 W. Old Liberty Rd., Winfield, MD 21784 lumour Inmediate cause (Final lisease of condition esulting in death) mongs Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I BPH 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical **Examiner**

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

Funeral

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be none.

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

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the Maryland

Examiner as the burial-transit Physician/Medical use ed by the a detached for Completed by To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be ို Certification:

After this certificate

IF FEMALE:

29a. Certifier

(Check only one)

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

> 24a. Was an autopsy performed? Yes 2 No 1□ Yes

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

6 Could not be determined 3 ☐ Suicide 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Parint) CHACKO

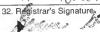
Stoner

westmuster

State Registrar

Medical

31. Date filed (Month, Day, Year)





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 05-17-2008 **Physician** 510 A Lewis E. Bradford /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facilify Name (If not institution, give street and number) Examiner Baltimore Middle River Ivy Hall If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. | 8. Date of Birth (Month, Day, Year) 08-04-1923 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 5. Social Security Number 6. Sex South Carolina 1 ₹ M 2 ☐ F 84 718-01-1933 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Director Nottingham MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21236 9525 Fox Farm Rd Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black. White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛱 No Specify: White Completed by 3 ₩ Widowed 4 Divorced 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Army & Navy Military 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary McDowell Harry Bradford ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9525 Fox Farm Rd Nottingham MD 21236 Anita Pike (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Cem. 05-21-2008 | Owings Mills, MD 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 9705 Belair Rd Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due o (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of). mm Due to (or as a consequence of) Dubel Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury

Hospital or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician After this certificate has been signed by the funeral director, page 2 should be detached 24 hours after death. e Funeral Director: After filled in by the

Funeral

Director

ns 23a or 28a-f show must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be nn once.

Physician

/Medical Examiner

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 Le ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

D 71464

20/03

State Registrar

completely within 2

Medical

31. Date filed (Month, Day, Year)

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. ENTAN ST Shite 308, BALTIMORE MI) 21201 HASHM!

32. Aegistrar's Signatute 1 9 9 18 A 2008

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		1- For State Registrar	or maryland	•	tificate of				, g	Reg. No	20	118	1545
Physicia dical Exami	an/	1. Decedent's Name (First, Middle, La	est)			В	owi	e	2. Date of D Month May 5, 2		Year		Time of Death 0010 hrs
*		4a. Facility Name (if not institution, g Sinai Hospital	ive street and number)			4b. City, Tow Baltimo		ocation of D			c. County of D	eath	
Funeral Director			Sex 7. Ag	e (In yrs. Ia	est birthday) Yrs		Year Days	If Under 2	4Hrs. 8. Date of Min. 09	Birth (MN	96 FG	. Birthpla oreign Countr	145
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locat	ion	1					10	d. Inside City Limits
	tor	MD Montgo	omery		Poto	mac	vie			10n C	tizen of What	1 Country	Yes 2X No
the Mai a or 28	Director	12641 Toby To	wn Drive				208	354			U.S.A	-	
death with or items 23 must be no	Funeral	11. Marital Status 1 X Never Married 2 Marrie	12. Was Decedent Armed Forces 1 Yes 2						? (Specify Yes or uerto Rican, etc.)	No-	White, et		Indian, Black,
irs after iural",	by	3 Widowed 4 Divorce 15. Decedent's Education (Specify	ed If Yes, Give Year or Dates: only highest grade con	npleted)	16a. Deceder	Yes 🔏	,	specify: n (Give kind	d of work done	16b	Specify: Kind of Busine		
J36 thin 72 houne. ne. than "natededical Exa	Completed	Elementary/Secondary (0-12) 6th grade	College (1-4 or		during m	nost of workin tuden	g life. D				Scho	ol	
Ore, MD 21215-0036 set and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f she ther traumatic event, the Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, La Charles Bowie	Jr.				F	elic	Name (First, Middle cia Nor	ris			
MD 21 d 2 should th and M6 n 27 is m2 numatic e	2	19a Informant's Name/Relationship Florice	(Type, Print) -Grandmot	her					Dr., P				
imore, MD Pages 1 and 2 st ment of Health an iant: If item 27 i		20a. Method of Disposition 1 X Burial 2 Cremation		20b. F	Place of Dispos crematory or of	ther place)			Date 5/19/08		Location - Ci	•	
Baltimore, permit. Pages I ar Department of Her Important: If ite injury or other tr		21. Construct of Funeral Service Licensee: 22. Name and Address of Facility March F/H West										21215	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listonly one cause on each line.									1	Approximate Interval Between Onset and	
/Medical xaminer			a. Complications of Due to (or as a cons			n						+	Death
-	ь	Sequentially list conditions, if any, leading to immediate	b Due to (or as a cons	equence of	n):		_					+	
d sit	Examiner	cause Enter Underlying Carise	c. Due to (or as a cons	equence of	f):				<u> </u>			+	
oe executed cian and rial - transit	dical		d. X AMENDED 19	a per	fh g8	79 5–2	1-0	8 vt					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✔ Unkno	23c. If yes, outco 1 Live birth 4 Pregnant at		2 Fe	etal death ther (Specify	3 [Ectopic p	regnancy	2	3d. Date of de Month	livery Day	Year
ires that the de signed by the detached f	by Phy	Part II. Other significant condition		h but not re	esulting in the	underlying ca	use giv	en in Part				te to the	e cause of death?
of Vital Records, I ng Physician: The law requires ther this certificate has been sig neral director, page 2 should be	Completed								24a. W	/as an utopsy erformed	24b. We	re autop	osy findings available appletion of cause of
ital Recician: The coertificate	e Cor	25. Was case referred to medical	<u> </u>			26.	Place o	of Death (C	1 Y Y	es 2	No 1	Yes	2 No
Vita hysicia this ce	To Be	examiner? 1 ✓ Yes 2 No		ent 2	ER/Outpatien				Nursing Home 5			Other:	
ion of tending Pheath.		27. Manner of Death 1 ✓ Natural 5 Pending 2 Accident Investig		ury Year)	28b. Time of	Injury 280		at Work? es 2 N		ibe how i	njury occurred		
Division pital or Attendir ours after death. eral Director:	Certification:	3 Suicide 6 Could n 4 Homicide	ot be 28e. Place of Ir	njury - At ho	ome, farm, stre	eet, factory, o	ffice bui	ilding, etc.		on (Stree m, State)		or Rural	Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funcral Director:	Medical C		ician: To the best of mer:On the basis of exa										
+ # F S	Me	29b. Signature and title of certifier	Ha 10	av			icense D.C.M	number I.E.	·		d. Date signed ay 5, 2008	(Month	i, Day, Year)
5		30. Name and address of person who Carol Allan, MD Assis	no completed cause of cant Medical Exa		23a) 111 Penn	Street Ra	altimo	re. MD 2	21201				
	tate	31. Date filed (Month, Day, Year)	32. egistra	ar's Signati		oals s		10, WID Z				75a	
Regis	trar	MAY 21	2008 Stelle	an A	S ASD								

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Jerome 14: 35 PM BATES May 19 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Sinoi Hospital of Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months 1**X** M 2□ F 43 Director Maryland **213-06-1721** 04/26/1965 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show 1 Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 3614 Spaulding Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Evandance. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Black Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Mechanic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Burrell Mary E. Bates ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Bates / Mother 3614 Spaulding Avenue, Baltimore, Maryland 21215 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/24/2008 Lansdowne, Maryland Zion Cemetery 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Sephic Shock disease or condition resulting in death) 24h /Medical Due to (or as a consequence of): Examiner 48 liver tulus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi Sepers Page 1 24 h Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 Yes 2 No 2 No 1 ☐ Yes 1 ☐ Yes Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) Hospital or Attending Pl 24 hours after death. Funeral Director: After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Vounatour May 19 HD DES 000 2008

Registrar
DHMH 17 Rev 1/2001

State

Patient known as

ct

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

MD

Sina

Hospital

32. Redistrar's Signature

VanaPaun

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	otato or marytane	Cei	rtificate of l	Death	ornar r ry	Reg. No.	08	6471
A.	Dhooisi		1. Decedent's Name (First, Middle, Last)					2. Date of De	eath	Voar	3. Time of Death
	Physici Medic/		George J.	Bernier, Jr.				May		2008	8:02 a м
	Examin	er	4a. Facility Name (If not institution, give s 1800 Edgewood Road			4b. City, Town, or Baltimor		h	4c. County Bal	y of Death timore	<u>5</u>
	Funeral Director		5. Social Security Number 228-22-9379 6. Sex	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bin (Month, Date July 2	th Year) 5, 1926	9. Birthp Coun	lace (State or Foreign rginia
	nd ,		Usual Residence of Decedent	100 Cibr	, Town or Lo	antion				-	
	shov	ō	Md. Baltimor		timore					1	0d. Inside City Limits 1 ☐ Yes 2√☐ No
	the N 28a-f	rect	10e. Street and Number	e Dai	CTIIIOT	10f. Zip Code		I	10g. Citizen of	What Cour	
	h with	iO le	1800 Edgewood Roa	ad			1234			USA	
	ems 2	Funeral Director		12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	specify Yes or No to Rican, etc.)	0- 14. Rae	ce - Americ	
036	be filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Exteniner must be notified at	by	1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 🛣 No		, , , , , , , , , , , , , , , , , , , ,	Specify: White		
5-0	72 hc "natu dical	etec	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced (Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo	rking	16b. Kind of B	lusiness/Ind	fustry
2121	filed within Hyglene. rther than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Master		Brewing			
Baltimore, Maryland 21215-0036	12 should be filed wand Mental Hygie n and Mental Hygie is marked other t raumatic event, th	To Be (17. Father's Name (<i>First, Middle, Last</i>) George J. Bernier	, Sr.			Mary	Hulche			
, Mar	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		Ms. Edie Bernier/		1	ng Address (Street Edgewood			ore, City or Town		
more	0 0		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify)	emoval from State	emetery, crer	sition (Name of matory or other plac SS Cemete	20c. Location Ricl	- City or To hmond	<i>'</i>		
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	e d	22	Name and Address	owson Fu ork Rd.	neral H	ome, Ing	8 ₄ 4	
			23a. Part1. Enter the diseas or complications of heart failure. List only on	onlions that caused the death	. Do not ent					104	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. Sev-	ne	Emp		ema			Onset and Death
	Examiner			Due to (or as a consequ	erice or).		1				
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ence of):						
68760,	rtificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as a consequ	ence of);						
	ntificate ng phy as the	Medical									
O. Box	The law requires that the death cer tte has been signed by the attendir rage 2 should be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	□Ectopic pregnancy □ Other <i>(specify)</i>				ate of delive	ery Day Year
s, P.O	es that igned by be deta	by Ph	Part II. Other significant conditions con	tributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use cor	itribute to th	ne cause of death?
ord	w require been sig should b							17/2	Yes 2□ No	3 ☐ Prob	ably 4 Unknown
or Vital Records,		Completed						24a. Was auto perf 1∐ Yes			psy findings available mpletion of cause of
/ita	Physician: The rithis certificate ral director, pag	Be (25. Was case referred to medical examiner?			Ĭ		ath (Check only			
or	Physic this can dire	7°	1 Yes 2 No □	lospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatier 28b. Time o	nt 3 DOA Oth	4 Li Nursing i		idence 6 🗆 Ot		y)
on	Ilng After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	yat k? Yes 2∐No	28d. Describe	how injury occu	rrea	
Division	I or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify				28f. Location City or To	(Street and Num own, State)	ber or Rura	al Route Number,
	Hospita 4 hours Funeral tely filled	Medical Ce	29a. Certifier (Check only one) 2 Medical Examir	sician: To the best of my knowner: On the basis of examinat and manner stated.	vledge, deat ion and/or in	h occurred at the tire evestigation, in my control	ne, date and place	e, and due to the urred at the time	e cause(s) and m	nanner as s	tated.
	To the within 2 To the comple	Me	29b. Signature and title of certifier	Idous >	7)	29c. Licens	e number 7 7 2 7		29d. Date sign	ed (Month,	Day, Year)

State

Registrar

31. Date filed (Month, Day, Year)

MAY 2 1 2008

2011

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & CHARLES 51. BALTO, ND 21204

			Please Type or Pri						•	ible.	
			1 State	aryland /			lealth and M	lental Hy	giene		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cen	rificate of	Death	2. Date of De	Reg. No	3, Time of Death	0
	Physicia /Medic		Havold Cox					May	Day 15	2008 1128A	м
	Examin Funeral	er	4a. Facility Name (If not institution, give street and number) Nor Howell Hospital 5. Social Security Number 6. Sex 7. Ag	tal Ce	ente	If Under 1 Year	Location of Death	8. Date of Bin	4c. Count	9. Birthplace (State or Foreign	ign
	Director		219–40–4079 1 M 2 □ F Usual Residence of Decedent	66	Yrs.	Months Days	Hours Min.	(Month, Da 9–29–19	41	Couintry) SC	
nyland	dat	_	10a. State 10b. County	10c. City, Tov	wn or Loca	ation				10d. Inside City Limit	
the Ma	28a-f s otified	Director	MD Baltimore 10e. Street and Number	Ran	ndalls	town 10f. Zip Code			10g. Citizen of	. 1 □Yes 2∑N	io
th with	23a or ist be i		4266 Mary Ridge Drive				1133		USA	what Country:	
Pages 1 and 2 should be filled within 72 hours after death with the Maryland	Department of Heatin and Mental Hyglene. Importment of Heatin and Mental Hyglene. any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 □ Yes 2 Married 17. Was Decedent Armed Forces? 1 □ Yes 2 Married 17. Was Decedent Armed Forces?)		vas Decedent of H Yes, specify Cuba ☐ Yes 2 No	lispanic Origin? (Spo an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ce - American Indian, ck, White, etc. y: African-Americai	n
72 hor	'natura dical E	eted	15. Decedent's Education (Specify only highest grade completed)	16a	a. Decede	ent's Usual Occup	pation during most of work d)	ing	16b. Kind of E	lusiness/Industry	
within	r than '	Completed	Elementary/Secondary (0-12) College (1-4or s	·		o not use retired Attendant	d) -		Highfie	ld Condominium	
oe filed	d other	8	17. Father's Name (First, Middle, Last)		-45-1		18. Mother's Name				
hould	nd Men marke matic	2	Loris Williams 19a. Informant's Name/Relationship (Type. Print)	16	h Mailine	Address (Street	Anna Mae I and Number or Run		ar City or Town	State Zin Code)	
and 2 s	Health and Mental Hyglene. em 27 is marked other than other traumatic event, <u>the M</u> e		Malvenia Cox-Wife		4266 N	Mary Ridge	Drive, Rand	allstown	n, MD 2113	3	
ages 1	t: If iter		20a. Method of Disposition ↑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place cemet		ition (Name of atory or other plac netery	^{5–21-}	Date OR	20c. Location Woodla	- City or Town, State	
permit. F	Department of Important: If it any Injury or o once		21. Signature Funeral Service Licensee	//	22.	Name and Addre	ss of Facility Wyli	e lunco	I fame P.	A. of Balto. Co.	-
	_ = a a		23d Part Friter the disease, or complications that cause	the death. Do			y Road, Ramo		•	Approximate	123
	ysician		Immediate Cause (Final disease or condition	ine. APVOS			Cardi			Interval Between	
	ledical aminer			a consequence	e of):			0000	C. O.	0,3(2,3)	
p	sit	iner	Securitically list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence	e of):						
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The law requires that the death certificate be executed	been signed by the attending physician should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Fetal deat		Ectopic pregnancy Other (specify) _	/			te of delivery onth Day Year	
requires tha	sen signed I lould be det	þ	Part II. Other significant conditions contributing to death b	nut not resulting	in the unc	derlying cause ĝiv NEIII+	en in Part I.		tobacco use con Yes 2 No	tribute to the cause of death?	√n
n: The law	2 5	Completed	25. Was case referred to medical		-			1□ Yes	psy ormed? 2 No	Were autopsy findings availab prior to completion of cause of death? 1 Yes 2 No	ole f
nysicla	directo	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatie	ent 2 ☐ ER/O	Outpatient	3DOA Oth	er: 4 Nursing Ho		one) idence 6 ⊟Ot	her (Specify)	
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al or At	I Direct	ertific	determined 286. Place of Inj	jury - At home, f tc. (Specify)	farm, stree	et, factory, office		28f. Location (City or To	(Street and Num wn, State)	ber or Rural Route Number,	
To the Hospital or Attending Physician:	within 24 nous after to ceam. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination a	ge, death and/or inve	occurred at the tirestigation, in my control	me, date and place, opinion, death occur	and due to the red at the time	cause(s) and m	anner as stated. , and due to the cause(s)	
P.	Мил То 1	M	29b. Signaturgand title of certifier Teller	Mile	lale	29c. Licens		60	29d. Date signed $\mathcal{H}ay$	15, 2008	,
	10		30. Name and address of person who completed cause of c	leath (Item 23a)	(Type, P	rint) MD 540	1 old	COUV	+ PM	rocl	
	Sta Registr		31. Date filed (Month, Day, Year) 32 Registr	rar's Signature	Spe		Rand	alist	own,	MD 21133	,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** O:CORM GEORGE HAMILTON COOK 5 /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** VA Maryland 5. Social Security Number Health If Under 1 Year . Age (In yrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1**12** M 2□ F Months 213-26-3502 Usual Residence of Decedent JULY 10 1ARYLAN Director the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shamp Injury or other traumatic event, the Medical Examination and be notified. 1 Yes 2 No by Funeral Director MD EASTON TALISOT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2160 STONEY ROWE CIRCLE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PHOTO JOURNAUST JOURNALISM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RUTH ST, CLARE GEODGE ဂ္ COOK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , FASTON MD 21601 /WIFE STONEY RIDGE CIRCUS catherine bardnur - cook 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HANDUNZ, MORTHAN ANATOMY GIFTS PEGISTRY IMAY 21,2008 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral/Service Licensee STOIC OM SUNGHAN SUISCH YELLEN CEST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ภหมอเมก neumania disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ No certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 1 Yes ours after death. eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 300 Medical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) MAY 21 2008

Melecia:

inntes,

VA Maryland Health Care System, Perry Point, MD 21902 32.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

lume Kindun to Physician Cook, Bearde H

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Year Nicholas G. Contox 02:18M 2008 Ma 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Saint Agnes Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07-23-1934 9. Birthplace (State or Foreign **Funeral** West Virginia 1 X M 2 □ F Months Days Hours Min 217-32-9792 73 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examiner must be negliged at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Baltimore 1 ☐ Yes 2√ No Directo Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd #2611 21234 IISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐Yes 21 No ģ Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dental Technician Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George N. Contox Aradnid Blavos 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anna Contox (Wife) 8800 Walther Blvd. #2611 Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bavview Crematory 05-19-2008 Baltimore, MD 21. Signature of Funeral Service Ucensee 22. Name and Address of Facility Schimunek Funeral Home are 9705 Belair Rd Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Artery disease **Physician** Due to (or as a consequence f): /Medical Examiner chemic Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Renal Acute Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 TYes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

law requires that the death certificate be executed Records, P.O. Box 68760, Division of Vital XOL NOU To the Hospital or Attending Physician;

Baltimore, Maryland 21215-0036

physician and s the burial-tran attending p for use as t page 2 s Certification: To 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Aldandashi May, 16, 2008 P 20657

State Registrar 900 Caton AVE,

Registrar's Signature

Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHMOUD Aldandashi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 0635 AM Alvin L. Crowetz May 18 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Under 1 Year | If Under 24 Hrs. Agnes Hospital 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Hours **Funeral** Months Days 1⊠M 2□F Yrs Maryland 212-22-0858 83 Nov. 16,1924 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 21 No Director Baltimore Catonsville Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 1209 White Mills Road 21228 USA Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23s ury or other traumatic event, the Medical Examiner must by Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S.
Armed Forces?
1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1943-51 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Newspapers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Solomon Theodore Crowetz Sarah Berlin ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Martin Crowetz 519 K Street, N.E., Washington, D.C. 20002 Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 5/21/2008 Crownsville VA Cem. Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service Licensee Funeral Home of Catonsville, Inc. M01490 1630 Edmondson Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Pancreatic Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dutlet unknown Gastne Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence or) The law requires that the death certificate be executed 18 days Pneumonia attending physician and for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown pulmonary embolism Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No e Husion 24a. Was an autopsy performed 2 No 2 Z No Vital malnutrition Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ Division or this 27. Manner of Death Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural

Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29a. Certifier (Check only one)

State Registrar 29b. Signature and title of c

31. Date filed (Month, Day, Year) MAY 2 1

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Natalie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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H 90 32. Régistrar's Signature

29c. License number

Ave Baltimore.

29d. Date signed (Month, Day, Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month 05 17 Day 2008 04:25 Collins Cheryle Yvonne /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson Baltimore Gilchrist Hospice If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months 214-56-4496 58 **Director** 03 08 50 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director MD NA Baltimore 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? ō 21214 U.S.A. 5415 Hillburn Ave Apt 1 23a death v Funeral items 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status • filed within 72 hours after de if Hygiene.
other than "natural", or item Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Catonsville Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: if Item 27 is marked other that any injury or other traumatic except. 12th grade 5yrs+ Administrator Community college 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Williams Marie Mathis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2207 North Eutaw Place Apt #1, Baltimore, Md Jamaal Wilson-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 5/22/08 Woodlawn, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility arch F/H West 300 Wabash Ave, Baltimore, Md 21215 Three 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ENDSTAGE eare /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown for Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page certificate 1☐ Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at Work? Hospital or Attending 5 Pending investigation Natural 2 Accident (Month, Day Year) 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records,

State Registrar

DHMH 17 Rev 1/2001

completely

(Check only

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-Rifaullaner 555 W - Towsantown 31. Date filed (Month, Day, Year) Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	state of Ma	ryianu / i		tificate of i	Death	_	Reg. No.	0.50	16477
П	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of De Month	Day	/ Year	3. Time of Death
4	/Medic	_	Joan Ann Cave						May	17,	2008	9:45 P M
8	Examin	er	4a. Facility Name (If not institution, give stre	eet and number)				Location of Death		40.	County of Death Harford	
			627 Sequoia Drive 5. Social Security Number 6. Sex	7. Age	(In yrs. last bii	rthday)	Edgewood If Under 1 Year	if Under 24 Hrs.	8. Date of Bir	th	9. Birth	place (State or Foreign
L	Funeral Director			2 X F	74	Yrs.	Months Days	Hours Min.	Nov. 1	<i>y, Year)</i>	Coui	hio
	ryland how at		10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2X No
	e Ma Sa-f s	Director	Maryland Harford	<u></u>		Edge	ewood					
	vith th	Dir.	10e. Street and Number				10f. Zip Code	. 4.0		_	izen of What Cou	ntry ?
	sath v	eral	627 Sequoia Drive	Was Decedent E	ver in ILS	13 \	210		ecify Yes or No		USA 14. Race - Americ	can Indian,
36	be filed within 72 hours after death with the Maryland tital Hygiene. So ther than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	y Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:			f Yes, specify Cuba I □ Yes 2⁄2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Black, White, Specify: Whi	etc.
8	2 hour	ted t	15. Decedent's Educat	tion	16a	. Deced	lent's Usual Occup	ation during most of work	king	16b. K	ind of Business/In	
215	ithin 7, ne. nan "n e Medi	Completed by	(Specify only highest grade c	College (1-4or 5-	-)	life. I	DO NOT use retired	dunng most of work d)	ang			
121	e filed w al Hygier other th		12 17. Father's Name (First, Middle, Last)			НО	memaker_	18. Mother's Nam	e (First, Middle		n Home Surname)	
anc	be d d	Be	Russell (unk) Benne	ett				Helen M	•		,	
2	should be and Mental s marked o umatic ev	မ	19a. Informant's Name/Relationship (Type.		198	o. Mailir	g Address (Street	and Number or Ru			or Town, State, Zij	o Code)
Z	d 2 th a trau		Susan A. Giannini	/ Daught	er 3	Mc	Dermott I	Road, Pyl	esville	. MD	21132	_
ore,	es 1 a of He item		20a. Method of Disposition 1 Burial 2 Cremation 3 Ren		20b. Place o	f Dispo	sition (Name of natory or other plac	ce)	Date		ocation - City or T	own, State
Ë	Pages ment of I ant: If its ury or o		4 □ Donation 5 □ Other (Specify)	iovai irom State	Hillt	qo:	Service (Corp 5-2	1-08	Tow	son, Mar	yland
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other		21. Signatur of Juneral Service Licensee	Monde	,	M	Name and Addre	meral Ho	me, P.A		MD 2100	00
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused	the death. Do	not ent	31 / COKES er the mode of dyir	sbury Rd. ng, such as cardiac	or respiratory a	acon ,	MD ZIU	Approximate Interval Between
	Physician		shock, or fleart failure. List only one Immediate Cause (Final	Cause on each im	0.	-	1051.15	/umo,	1A-11-1	2/6	THIE	Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a	consequence	of):	0//00	, -0. 101	01/10/		,200	- 101/103
k	Examiner		Sequentially list conditions, b.									
	る人 意	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	i consequence	of).						
	xecuti and	xan	that initiated events c. resulting in death) Last	Due to (or as a	consequence	of):						
68760,	ificate be executed g physician and as the burial-transit	Sal	d									
68		ledical										
P.O. Box	requires that the death cer neen signed by the attendin hould be detached for use	Physician/M	IF FEMALE: 23b: Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No 9 □Unknown	If yes, outcome particles of the second of t	2 Fetal deat		⊒Ectopic pregnanc] Other <i>(specify)</i> _	у			23d. Date of deliv Month	very Day Year
	w requires that the debeen signed by the should be detached	by Pt	Part II. Other significant conditions contri	•	t not resulting	in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
rds	equire en sig ould bo	ed b	LIKELY LUNG (A	LER			-		uz	Yes 2	□ No 3 □ Pro	bably 4 Unknown
Division or Vital Records,	e law has b je 2 s	Completed							24a. Was auto perf 1□ Yes		prior to co	opsy findings available ompletion of cause of
ita		a	25. Was case referred to medical	42.00				26. Place of Dea			,	72
r <	di S	To B	examiner? 1 ☐ Yes 2 ☐ No Hos	spital: 1 Inpatie	nt 2 ER/O	utpatier		4 LI Nursing n	ome 5⊡Res	idence	6 □Other (Spec	ify)
o uoi	Attending Ph r death. ector: After thi by the funeral		27. Manner of Death 1	28a. Date of Injur (Month, Day		Time o Injury	Wo	ryat rk? IYes 2 ∐No	28d. Describe	how inju	ry occurred	
Divis	l or Atte after de a Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injubuilding, etc.	ry - At home, f . (Specify)	arm, str	eet, factory, office		28f. Location City or To	(Street al	nd Number or Ru e)	ral Route Number,
	To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by the	edical C	29a. Certifier 1- Certifying Physic (Check only one)		examination a							
_	To the within To the complex c	M	29b. Signature and title of certifier	- /			29c. Licens				ate signed (Month	, Day, Year)
			1/20 hads				13	8808		5	119/08	
	10		30. Name and address of person who com SENHAL SIRIS 31. Date filed (Month, Day, Year) MAY 2 1 2008	pleted cause of de	eath (Item 23a)	(Type,	Print)	YONY SUIT	v A Sin	chy.	(Me Z	1017
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	losu	W				*	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6:30 A_M **Physician** Margaret Frances Davidson May 2008 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 819 Ridge Road Finksburg Carroll Date of Birth (Month, Day, Year) 12-8-1911 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours 96 Months Days Min 213-34-0280 1 □ M 2 X F Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 X Yes 2 □ No MD Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. Funeral 6100 Everall Avenue 21206 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ (M) No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ş 3 Widowed 4 □ Divorced 'natural", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Manatone. Elementary/Secondary (0-12) College (1-4or 5+) Communications Telephone Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Wharry Anne Lauer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 819 Ridge Road, Finksburg, MD Eileen Schauermann/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp: 05/23/2008 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liquinse 22, Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CAN HECU /Medical Due to (or as a consequence of): Examiner Due to (or as) consequence) f): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Completed by Physician/Medical the as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) signed by the a 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? thatis Osteopenn 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificate has be lirector, page 2 s autopsy performed? Yes 2010 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury s after dea. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinating and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 2 ☐ Medical Examiner: (Check only one) n the basis of examination d manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Item 23a) (Type, Print) cause of 30. Name and address Voterenda-Bux 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day D'Avanzo 17, 2008 Crescenzo 5:23 PM May 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford Co. Upper Chesapeake Health Rel Air Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Age (In vrs. last birthday) Days Months Hours Min 1 □XM 2 □ F 577-44-1420 73 1934 District Col. 18, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Harford Joppa Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 118 Chell Road United States 21085 12. Was Decedent Ever in U.S. Armed Forces? 1,⊟Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2KNo Specify Specify. 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Grocery Grocer 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Filomena Trama Vincent D'Avanzo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3500 Cornwall Court Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type. Print) Christopher D'Avanzo (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 5/20/2008 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 7922 Wise Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Prlumaria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Natural 2 Accident (Month, Day Year)

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Examiner Physician/Medical 9 Completed Be ို Certification:

within 24 hours after useum.

To the Funeral Director; A

Physician

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Maryland 21215-0036

Baltimore,

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29b. Signature and title of certifier

2008

5 ☐ Pending investigation

6 ☐ Could not be

determined

3 Suicide

29a. Certifier

4 ☐ Homicide

29c. License number 0066102

1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause

pper Chesapeake Dr. Bel 500 U 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 2

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Funeral		5. Social Security Number 6. 5		ge (In yrs. la	st birthday)	If Unde	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth	9. Bi	irthplace (State or Foreigi Country)
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permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Marilan Evander must be notified at once.		19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	g Addres	s (Street	and Numbe	er or Rura	al Route Numb	er, City	or Town, State,	Zip Code)
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DHMH 17 Rev 1/2001

		1 - State Registrar	,		rtificate of			Reg. No. 200	18 1.6482
Physi	ician	1. Decedent's Name (First, Middle, La					2. Date of Dea	ath	3. Time of Death
/Me	dical	FAIRICIA	ANN	FRI	ESHLEY		05–18	3-2008	1:30 M
Exam	niner	4a. Facility Name (If not institution, given 10 SHARON COU			4b. City, Town, o	r Location of Death		4c. County of P.G.	Death
Funera	al	5. Social Security Number 6. S	ex 7. Age (In vi	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt		. Birthplace (State or Foreign
Directo		577-56-7979 Usual Residence of Decedent	□M 2ŽF	5.5 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da 05-27-	-1942 W	ASHINGTON, DO
yland ow at		10a. State 10b. County		City, Town or Lo	cation				10d. Inside City Limits
e Man a-f sh tiffed	cto	MD CALVERT	· I	NITNUE	GTOWN				1 XYes 2 No
with that or 28	Director		. T.		10f. Zip Code	- 2 0		10g. Citizen of Wha	-
leath v	Funeral	315 HOILE LAN	12 Was Decedent Ever in	U.S. 13.1		539 lispanic Origin? (Sp	ecify Yes or No	U.S.A	American Indian,
Ind 21215-0036 be filed within 72 hours after death with the Maryland tital Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	۵	3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black,	White, etc. BLACK
5-0036 72 hours af 'natural'; or	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occup	eation during most of work d)	ing I	16b Kind of Busir US depa	ness/Industry rtment of
121 within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			RCE SPEC	ı	T . 1	
ifiled Hygin other	Be	 Father's Name (First, Middle, Last, 		HOHM	V KEBOOI	18. Mother's Name		Maiden Surname)	
Aaryland 2 2 should be filed v and Mental Hygie is marked other raumatic event, th	P B		ller			Etta	Gray		
ore, Marylal es 1 and 2 should b of Health and Ment fitem 27 is marker rother traumatic e		19a. Informant's Name/Relationship (Darnell Freshle	Type, Print) y/Son	19b. Mailir 9 9 0 7	ng Address (Street Raintre	and Number or Rur ee Way C	al Route Numbe linton	er, City or Town, Sta N. MD 20	ate, Zip Code) 735
Baltimore, Maryland 2121 bernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. mportant: If item 27 is marked other than " my injury or other traumatic event, the Me		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State Ha	Place of Dispo cemetery, crer rmony	sition (Name of matory or other place Memoria	il Pk 5-	23-08	20c. Location - Cit Landove	ty or Town, State
Baltimo	ouce.	21 Signature of Funeral Service Licer	See July	1 (2. Name and Addre	ss of FacilitRon orth Ave	ald Ta . Balt	ylor II imore,	FH MD 21201
Merc		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that prused the de one cause on each line.	ath. Do not ent	er the mode of dyir	ig, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
Physician	_	Immediate Cause (Final disease or condition resulting in death)	a	Myou	UD45/-	ASIA			6 MWW
/Medica Examine	_	Toolishing in dodsity	Due to (or as a conse						
	je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conse	equence of):					
ecuted transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
(68 /60, infilicate be executed ing physician and as the burial-transit		resulting in death) East	Due to (or as a conse	equence of):					
68 / 60 ifficate be e g physiciar as the buria	Medical		⊾d						
BOX leath cert attending		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf preg		Ectopic pregnancy	,		23d. Date of	
BCOTGS, P.O. BOX law requires that the death ce as been signed by the attendi 2 should be detached for use	hysician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown		Other (specify)			Month	Day Year
cords, P.O. w requires that the deben signed by the should be detached	Ω.	Part II. Other significant conditions of	ontributing to death but not re	esulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribu	ite to the cause of death?
ords equires en sign	ed by	DIADETES					101	∕es 2 / ∖ o 3[☐ Probably 4 ☐ Unknown
Hecords, he law requires t s has been signe ge 2 should be c	ompleted						24a. Was autop	osy prio	re autopsy findings available or to completion of cause of
_ ⊥ ate	0	25. Was case referred to medical						2 No 1	th? Yes 2DNo
	o Be	examiner?	Hospital: 1 ☐ Inpatient 2[☐ ER/Outpatien	t 3 DOA Oth	er: 4 □ Nursing Ho			Daughter's (SpecifyHouse
Te fe	no: T	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor			now injury occurred	epeciny110 use
VISION Attending or death. rector: Afte	ertification:	2 Accident investigation 3 Suicide 6 Could not be		home form str		Yes 2 □ No	201		
LIVISION of all or Attending F safer death. If Director: After a in by the funeral or a property of the funeral or and a property or	ertif	4 ☐ Homicide determined	building, etc. (Spec	cify)	eet, factory, office		City or Tow	otreet and Number (vn, State)	or Rural Route Number,
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician; to the best of my kinner or the basis of examinand manner stated.	nowledge, death	n occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and mann date and place, and	er as stated. If due to the cause(s)
To th within To th	Me	29b. Signature and title of certifier			29c. Licens		;	29d. Date signed (I	Month, Day, Year)
/		Jun 1	tud		24	11240		05/1	9/2008
5		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type, I	Print) Le/Wile	ND,	4104	Bow	207/6
	state strar	31. Date filed (Month, Day, Year)	32 egistrar's Sign	nature		1	/	/	207/6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 15 M Physician Edwina Wilma Griffin /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. Cify, Town, or Location of Death Examiner Carroll County General Hospital Carroll Westminster 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Hours Months Days 1 □ M 2 □ F September 6 1931 Baltimore, Maryland 219 28 8550 76 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 햠 1 ☐Yes 2☐No be notified Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with "natural", or items 23a or 21157 USA 282 Winterberry Lane Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify Specify: þ 3 X Widowed 4 ☐ Divorced ear or Dates White Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Tax Consultant/Manager H & R Block Health and Mental Hygi em 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Charles Luerssen Lillian E. Conrad 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is 1609 Auburn Court Westminster, Maryland 21157 Donna E Farson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 5 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Injury 4 □ Donation 5 □ Other (Specify) Immanuel Lutheran Cem. May Baltimore, Maryland 22 2008 22. Name and Address of Facility
Lassahn Funeral Home Inc of Funeral Service License rices 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician resulting in death) /Medical Due (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner -transit the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ☐Yes 2☐No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 TYes Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy certificate Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? : After Certification: 5 Pending investigation 1 Natural within 24 hours arter occur.

To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

224

Registrar's Signature

S. C. C. C.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

WASNINGTON HTB WESTMIN

JEHREY (G1	USE Bloom Ton	Drink in D	laak laalat	bladale (Tanin	All Coming	Ava I amil	-1-	
UNK UNK			e or Print in B te of Maryland						0 1 -1 0
		I-For State Registrar		Certifica	ate of Death		Reg.	No. 200	W 1 W 1 W
Physicia Medical Examin		Decedent's Name (First, Middle TERREPEX CALL	,				Date of Death Month Date May 18, 2008	ay Year	3. Time of Death 0055 hrs
Harak		JEFFREY GAU 4a. Facility Name (if not institution)	4b. City, Town, o	or Location of Death	/lay 16, 200	4c. County of Dea	
4		University Hospital			Baltimore			N/A	
Funeral	i			ge (In yrs. last birt	hday) If Under 1 Ye Months Da		ζ.	MM/DD/YYYY) g. B Fore	ign
Director	-		1 X M 2 F	42	Yrs.	, , , , , , , , , , , , , , , , , , , ,	6-26-1	965	ountry) MARY LAND
any	=	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	٦	MD. N/	A	BALTI	MORE				1 X Yes 2 No
Maryls 28a-f	Director	10e. Street and Number			10f. Zip Code	102	10g.	Citizen of What Co	untry?
death with the Maryland or items 23a or 28a-1 sho must be notified at once.		1024 VINE ST.			212			USA	
death wi	Funeral	 11. Marital Status 1 Never Married 2 X Mar 	12. Was Deceden	?	Was Decedent of H If Yes, specify Cuba	iispanic Origin? (Speci an, Mexican, Puerto Ric		White, etc.	rican Indian, Black,
	by Fu	3 Widowed 4 Divo	1 Yes 2 rced If Yes, Give Yeer or Dates:	X No	1 Yes 2 N	o specify:		Specify:	BLACK
hours a natura Sxamii		15. Decedent's Education (Spec	fy only highest grade cor		Decedent's Usual Occupa during most of working lif			b. Kind of Business	s/Industry
36 lin 72 han "	plet	Elementary/Secondary (0-12) -12-	College (1-4 or -0-	5+)	CARPENTER			CONSTRU	CTION
15-0036 filed within 72 hours after death with the Maryland Hygiene. ed other than "natural", or items 23a or 28a-fshe i, the Medical Examiner must be notified at once	Completed	17. Father's Name (First, Middle, I				18.Mother's Name (Fi		den Surname)	
4 5 5 5 C	Be	ALBERT R. WAL				SUE C.			
MD 21 d 2 should th and Mer n 27 is man numatic ev	٩	19a. Informant's Name/Relationsh KIANE GAUSE (W		19t	o. Mailing Address (Stre $1024\ ext{VINE}\ ext{S}$				
imore, MD Z Pages I and 2 shou ment of Health and I lant: If item 27 is r or other traumatic		20a. Method of Disposition 1 XBurial 2 Cremation	0		of Disposition (Name of coory or other place)	emetery, D	ate 2	0c. Location - City o	or Town, State
Baltimore, permit. Pages I an Department of Hea Important: If iten		A Dending St. Other St.		KING	MEMORIAL PA		2008	BALTIMORE	, MARYLAND
Salti ermit. Separtn mport	Ī	21. Sugney e of Funeral Service	ouser JONATHA	N D. HIE	Name and Address	ss of Facility PHIL	LIPS FU	NERAL HOM	ſE, P.A.
Physician	\dashv	23a Trit I. Enter the disease, or o	complications that caused	the death. Do no					RÝLAND 21217 Approximate Interval
/Medical		f filure. List only one cause of the diagram of the filure cause (Final disease			, .				Between Onset and Death
xaminer		or condition resulting in death)	Due to (or as a cons						
	ě	Sequentially list conditions, if any, leading to immediate	b Due to (or as a cons	sequence of):					
	Examiner	cause. Enter Underlying Cause. (Disease or injury that initiated	c.						
executed ian and ian - transit	Exa	events resulting in death) Last	Due to (or as a cons	sequence or):					
e exect cian an rial - tr	dical	UNPENDED	AMENDED						
Box 68760 e death certificate b the attending physical for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of pregnancy				23d. Date of delive	•
K 68	cian	past 12 months?	I Live Ditti	t time of death	=	Ectopic pregnancy	′	Month	Day Year
Bo, le death the att	hysi	1 Yes 2 No 9 Unkr	9 Unknown						
Vital Records, P.O. Box 68760, sysician: The law requires that the death certificate be execute this certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - tran		Part II. Other significant condition	ons contributing to dea	th but not resulting	g in the underlying cause	e given in Part I.		cco use contribute to 2 ✓ No 3 Pr	o the cause of death?
ds, l	Completed by		· · · · · · · · · · · · · · · · · · ·				24a. Was an		autopsy findings available
COL	mple						autopsy performe	ed? death?	
Re n: The tificate or, pag		25. Was case referred to medical			26 Plac	ce of Death (Check onli	1 Yes 2	No 1	Yes 2 No
Vita ysicia his cer direct	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati	ent 2 🗸 ER/O		Other: Nursing H		esidence 6 Oth	er:
n of Vit ding Physic L. After this of		27. Manner of Death 1 Natural 5 Dead	28a. Date of Inj (Month, Day May 18, 200	ury 28b. 7 Year) 0015	·	- Isi	d. Describe hov ibject shot	v injury occurred	
Sior Attend death death ector:	catic	Pendi	igation			Yes 2 V No	-		Dural Banda Muselan City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Certification:	3 Suicide 6 Could 4 Homicide	not be	njury - At nome, ta side vehicle	arm, street, factory, office		or Town, Stat		Rural Route Number, City D
Hospi 24 hou Funer etely fil		29a. Certifier 1 Certifying Ph	ysician: To the best of n	ny knowledge, dea					
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		niner:On the basis of exa and manner stated						
	2	29b. Signature and title of certifier	1/1	X		nse number C.M.E.		9d. Date signed <i>(N</i> May 18, 2008	nontn, Day, Year)
(1)		30. Name and address of person v	who completed cause of	death (Item 23a)			L		
10		Melissa Brassell, MD	Assistant Medica	1.01	111 Penn Street,	Baltimore, MD 21	201		
St	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	2				

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 05 **Physician** 07:02 AM 2008 20 Robert Allen Ganzermiller /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GOOD SAMARITAN HOSPITAL N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 27, 1972 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min. 1**X** M 2□ F 35 215-80-7209 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10b. County 1 □Yes 2 No Director Rosedale Baltimore Co. Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 United States 5482 Glenthorne Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🂢 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Archdiocese of Elementary/Secondary (0-12) College (1-4or 5+) Sacristan Baltimore 12 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental h Margaret Mary Ritter Bernard Joseph Ganzermiller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Rosedale, MD 21237 5482 Glenthorne Ct. Mrs. Margaret M. Ganzermiller/Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Holy Redeemer Cem. 5/24/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral equice Licensee Michael E. Canapp 22. Name and Address of Facility 5305 Harford Rd. Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPTIC SHOCK SECONDARY TO PHEUMONIA **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner IMMUNE DEFICIENCY SYNDROME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami and Due to (or as a consequence of): Physician/Medical the as nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Nhknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 PULMONARY 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Box 68760. Vital Records, P.O. ō

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хотріете ў filled in by the funeral To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

10

State Registrar

Medical

29a. Certifier

PRACHI

31. Date filed (Month, Day)

29b. Signature and title of certifier MD

Day, Year)

29c. License number RES 000

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOG GOOD SAMARITAN HOSPITAL, BALTIMORE MD 21239

32 Registrar's Signature

08-03714

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Shirley Greene	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.	101.0
Physician/	1. Decedent's Name (First, Middle,Last) Shirley Ann Greene 2. Date of Death Month Day Year	e of Death 40 hrs
Medical Examiner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	401115
	Sinai Hospital Baltimore N/A	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	(State or Foreign
nd show any <u>nce.</u> OF	10a. State 10b. County 10c. City, Town or Location 10d. ir	rside City Limits
the Maryland Sa or 28a-f show	10e, Street and Number 10f, Zip Code 10g, Citizen of What Country?	
er death with or items 23 r must be no		lian, Black,
12 hours after "natural" 1 Examiner eted by	or Dates:	
215-0036 be filed within 72 hour notal Hygiene. ked other than "matu ent, the Medical Exan Be Completed		10
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a Informant's Name/Relationship (Type Print) 4 1 19b Mailing Address (Street and Number of Rural Route Number City of Town State Zip Co	ode)
nore, Nages I and 2	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 20c. Location - City or Town, or crematory or other place)	State
Baltimore, permit. Pages 1 an Department of Her Important: If ite injury or other tr	21 Sonature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 33. Name and Address of Facility	is, wa.
Physician /Medical Examiner	Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease	roximate Interval ween Onset and Death
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	·
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	Carre Hallan O.C.M.E. May 16, 2008	ıy, Ye ar)
1	30. Name and address of person who completed cause of death (Item 23a) Carpl Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimpre, MD 21201	
State Registrar		-
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Birector		Usual Residence of Decedent	M 2 F	Y O Yrs.			MARCH	06,1988	untry) MARYLAND
any	ı	10a. State 10b. County	10c. City,	Town or Location				1	10d. Inside City Limits
land f show once.	ē	MARILAND N	IA		13	ALTIL	10RE	CITY	1 Yes 2 No
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene. 7 is marked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at once.	Director	10e. Styleet and Number	1/22 - 1/2	101.	Zip Code	1:1	17	. Citizen of What Cou	nuy?
with the		11. Marital Status	12. Was Decedent Ever in U.			panic Origin? (Spo			ican Indian, Black,
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윤합니	P, F		If Yes, Give Year or Dates:	1 Yes	2 No		ork done	Specify: (5)	LACK
2 hour: "natu	jed	15. Decedent's Education (Specify on Elementary/Secondary (0-12)	College (1-4 or 5+)			DO NOT use retir		OD. MITO OF BUSINESS/	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours al Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin	To Be	MARCELLUS 19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing Addr	ess (Stree	t and Number or R	tural Route Numb	er, City or Town, State	e, Zip Code)
MD and 2 shot alth and m 27 is aumatic		RHONDA C. HE	RRING (MOTHER	1662	WES	T NORTH	+ AVE. Y	BALTO. M	021217
rre, s 1 and of Heal If item		20a. Method of Disposition 1 Burial 2 Cremation 3		Place of Disposition (crematory or other pla		metery,	Date /	20c. Location - City of	r Town, State
Baltimore, permit. Pages I al Department of He Important: If ite		4 Donation 5 Other Specify:	a a Ki	NGMEN	1. PA	RK Q5-	21-08		WN, MD
Ball permit Depart Impor injury		1. Sign ture of Funeral Sorvice Licen	to Koans	22. Name 8	and Address	of Facility BR	QUN VI	RAITA	AL HOME
Physician		Part I. Enter the disease, or comp failure. List only one cause on ea	lications that caused the death.	Do not enter the mo	de of dying,	such as cardiac or	respiratory ares	t, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease a.	Multiple Gunshot Woun	ds					Death
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3876 rtificat ling ph	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	2 Fetal de	ath 3	Ectopic pregna	incy	Month	Day Year
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Ospital ospital uneral ly fille	O	4 Homicide determine	d (Specify) Local Streetian: To the best of my knowled	· · · · · · · · · · · · · · · · · · ·	t the time d			nd N. Mount Street	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical		r:On the best of my knowled r:On the basis of examination a and manner stated.	nd/or investigation, in	n my opinio	n, death occurred a	at the time, date a	ind place, and due to	the cause(s)
5 7 × 5	Me	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed (M	onth, Day, Year)
		Date III	MD		O.C.	M.E.		May 16, 2008	
3		30. Name and address of person who Donna M. Vincenti, MD	completed cause of death (Item Assistant Medical Exar		nn Street	, Baltimore, M	ID 21201		
St	ate	31. Date filed (Month, Day, Year) MAY 2 1 2	008 32. Registrar's Signate	ore loss	وع				
Regist	Ifali	MHINTE	The Balling of	-					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 200^{Year} 20^{bay} Lawrence Joseph Hunt 8:15 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5704 Roland Avenue Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 1 X M 2 7 F Months Days 218-22-8576 Feb. 81 14, Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyres 2 □ No Maryland Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 5704 Roland Avenue 21210 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Catholic Priest Religion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William John Hunt Lulu Josephine Peach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5704 Roland Avenue; Baltimore, Maryland 21210 William J. Watters, Pers. Rep. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Anatomy Board 5/20/2008 Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Finer Lativica Funeral Home of Catonsville, Inc. 290 1630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heaft failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ung Lancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

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ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

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12 should be filed w h and Mental Hygie 7 is marked other tl

permit. Pages 1 and 2 and 2 and 2 pepartment of Health an Important: If Item 27 is any injury or other trau

Baltimore, Maryland 21215-0036

physician and s the burial-trans attending p for use as t been signed by the should be detached page certificate

The law requires that the death certificate be executed

Box 68760

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Division of Vital Records,

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Examine Physician/Medical Completed by director Be Certification: To funeral filled in by the within 24 hours a To the Funeral L Medical

COPP		1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 No 2 No 24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence 6 □ Other (Specify)
27. Manner of Death TX Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier ertifying F	Physician: To the best of my knowledge, death occurred at the time, date and place, uniner: On the basis of examination and/or investigation, in my opinion, death occur	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day, Year)

29d, Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nomber 6

gistrar's Signature

and manner stated

State Registrar 29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar		Marylan		artment rtificate			and N	lental Hyg	jiene leg. No.	300	16189
H	Physici	ian	1. Decedent's Name (First, Middle, L	,							Date of Dea Month	th Day	Year	3. Time of Death
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, gr	Examir	ner	4a. Facility Name (If not institution, g St. Elizabeth No		,				Location	of Death		4c. Count	y of Death	
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Ť V	physician: this certific al director,	0 B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inp	atient 2 🗆	ER/Outpatien	t 3 🗆 DOA	Othou			me 5 ☐ Reside		her (Specify	•)
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	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying P	hysician: To the be	est of my know	wledge, death	occurred a	t the tim	e, date an	d place.	and due to the o	ause(s) and m	nanner as st	ated.
	ne Ho in 24 I he Fu pletel	Medical	(Check only 2 Medical Exa	miner: On the basi and manner	s of examinal	tion and/or in	estigation, i	in my op	inion, dea	th occurr	ed at the time, d	ate and place,	and due to	the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Hall Gertrude 2008 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Levindale Nursing Home 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10 15 39 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2√ F Months Days Hours 215-46-5413 68 SC Director Usual Residence of Decedent 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at 1 X Yes 2 □ No Baltimore Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. 4600 Pall Mall Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on the filed within 72 hours after one of Health and Mental Hygiene. 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Year or Dates: 2 3 ☐ Widowed 4 ☐ Divorced Black "natural", Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. 1 other than " event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Nurse Technician 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked c Nell Lewis Niel Wideman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is other tra 21215 4600 Pall Mall Road, Baltimore, Md Clyde Hall-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any Injury or o
once, 1 → Burial 2 □ Cremation 3 □ Removal from State King Memorial Park 5/24/08 Woodlawn, Md 4 Donation 5 ☐ Other (Specify) 21. Signature of funeral Service Licensee 22. Name and Address of Facility
March F/H West 2 a. Part1 the the disease, or complications that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Baltimore, Md 21215 Approximate Interval Between Onset and Death Im nedia e Cause (Final disease or condition resulting in death) ATHERO: **Physician** 180SC /Medical Due (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown n signed by the Part II. Other significant conditions contributing to h but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed peen Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was ar has autopsy perform certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🔲 Yes npatient 2 ER/Outpatient 3 DOA ۵ After this funeral 27 Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 | Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation ∠ ☐ Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 29a, Certifier critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760, P.O. Records, **Division or Vital**

Baltimore, Maryland 21215-0036

State Registrar

Medical

(Check only

29b. Signature and title of certifie

DHMH 17 Rev 1/2001

ted cause of death (Item 23a) (Type, Print)

Registrar's Sign

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

SPOSO

1 2008

31. Date filed (Month

MUD

NENUE

· BALTIMORE.

900 CATON

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar		laryland / De C	partment of I ertificate of			ene 0 0 8	16492	
× C	Physici	an	1. Decedent's Name (First, Middle	ı, Last)	11 -4	1600		2. Date of Death Month	Day Year	3. Time of Death	
	/Medi Examir		4a. Facility Name (If net institution	give street and number	Her	4h City Town	or Location of Death	mag	4c. County of Dea	0	
4	Examili	ier		morit	*	Re	Himore	2	Baltimo		
No.	Funeral		5. Social Security Number		ge (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,		rthplace (State or Foreign ountry)	
3	Director		179-12-4568	1 M XXF	86 Yrs.	World Days	Flours Will.	Dec. 20	,1921 PA		
	and and	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits	
	72 hours after death with the Maryland natural', or Items 23a or 28e-f show disal Examinat must be codified at		Marvland Balt	imore	Ra	ltimore Co	ou n ±v			1 □ Yes 2√2√No	
36		lrec	10e. Street and Number	LIIIOI C	, Da	10f. Zip Code	Julicy	10	g. Citizen of What C	ountry?	
		Completed by Funeral Director	28 Elmont Aven	Je		2120	06		USA		
	er dez		11. Marital Status	12. Was Decedent Armed Forces 1 Tyes 2	t Ever in U.S. 13	3. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh		
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heath and Mental Hygiene. If Heath and Mental Hygiene a file and the state of the standard of the standard of the standard of the standard of the standard of the solution at the standard of the solution at the standard of the solution of the standard of the solution of the standard of the solution of the standard of the solution of the standard of the solution of the standard of the solution of the sol		1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	led 1 ☐ Yes 21⊡ If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify: W	hite	
9			15. Decedent	's Education	16a. Dec	cedent's Usual Occup			6b. Kind of Business	/Industry	
121215-0036			(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4or	lite	ve kind of work done . DO NOT use retire	during most of work d)	ing			
			ll yrs.	N/A	Но	Jsewife				ing-Own Home	
Maryland		To Be	17. Father's Name (First, Middle, I				18. Mother's Name		,		
Ž			Thomas Henry Mo		19b. Ma	iling Address (Street		Leanna R	OCK City or Town, State,	Zin Code)	
			Lanny R. Heffne			D Peninsu]				360	
ore,	es 1 a of Hea f item r othe	dimension limited.	20a. Method of Disposition	•	20b. Place of Dis	position (Name of rematory or other pla			0c. Location - City of		
Ē	permit. Pages Department of it Important: If it eny injury or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☑ Other (St	3 Hemoval from State pecify) Entombment	,	of Faith	1	~2008 B	altimore.	Marvland	
Baltimore,	permit. Pa Departmer Important: eny injury		21. Someture of Funeral Service L	licensee		22. Name and Addre	Funeral H				
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			23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	only one cause on each	line.	201	0		st,	Approximate Interval Between Onset and Death	
1 .			disease or condition resulting in death)	a. Due to (or a	a consequence of):	l Lur	ig Can	cer			
4				b	3 d 00,130 d 20,100 d 1).						
		iner	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury		à consequence of).						
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Вох	e death certifical he attending phy ed for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy							23d. Date of delivery	
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	iling Physicien: The law requires the same state this certificate has been signe funeral director, page 2 should be connected.		Part II. Other significant condition	en in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown						
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Re								24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of	
ita		0	25. Was case referred to medical				26. Place of Death			3 2□ No	
<u>></u>		To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpati	ent 3 DOA Oth			nce 6 ☐Other (Spe	ecify)	
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	spite nours norel	edical	29a. Certifier 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the		(Check only 2 Medical E	xaminer: On the basis of and manner st	or examination and/or	investigation, in my o	pinion, death occurr	ed at the time, dat	te and place, and du	e to the cause(s)	
	To t To t E	Σ	29b. Signature and title of certifier	20 1		29c. Licens			d. Date signed (Mon		
•			Peterna /	my)	113	5756	1	Vay 19	,2005	
			30. Name and address of person v	the completed cause of	death (Item 23a) (Type	a, Print)	2000	R-1	26'	mD 21239	
4	Sta	te	31. Date filed (Month, Day, Year)	4-1	rar's Signature	, wen	received.	11000	more	" May	
	Registr		MAY 2 1	2008	JI A	and I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend 19a, perINF C879 5/30/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Voor Physician 15_ 11:03 A^M 2008 CALVIN CHARLES BURTON HARTUNG May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 217 Crocker Drive Apt. A Harford Bel Air If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min. Months 1**☆** M 2□ F Hours Director 212-03-4442 89 Aug. 6, 1918 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at Maryland Harford Bel Air Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 traumatic event, the Medical Examiner must be 23a 217 Crocker Drive 21014 USA Funeral Apt. A 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □Xes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced White natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineering Technician U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 John Henry Hartung

19a. Informant's Name/Relationship (Type. Print)

Ruth Elizabeth Hartung

Petry Hartung / Wife Sarah (unk) Fogwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other tr once. 217 Crocker Drive, Apt. A, Bel Air, MD 21014 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp 5-17-08 Towson, Maryland 21. Sign 1 of une of service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 4 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine g g law requires that the death certificate be exec Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No nas autopsy performed?

1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 | Yes 2 No 2 after death.

I Director: After the in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or To the Hospital of within 24 hours at To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 032295 15,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 200

DHMH 17 Rev 1/2001

State

Registrar

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MAY 21

2008

31. Date filed (Month, Day, Year)

6,5 W, MAC

32. Resistrar's Signature

Phank Below

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2008 **Physician** 6:04P MARY ALMA HARDESTY May 17, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Stella Maris Timonium Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan 25,1914 Birthplace (State or Foreign Country) **Funeral** 1□M XXF Months Days Director 218-10-0300 94 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County show "natural", or Items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 535 Dunkirk Road 21212 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 □ Divorced Completed iges 1 and 2 should be filed within 72 hc nt of Health and Mental Hygiene.

If item 27 is marked other than "natur or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norris Tilden Hardesty Lillie Rebekah Bowen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar
Important: If item 27 Is
any Injury or other trau Joan C Smith DTR 535 Dunkirk Road Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 □Cremation 3 □Removal from State Parkwood Cemetery 5/20/08 Parkville, Maryland □Donation 5 □ Other (Specify) ignature of Funera 22. Name and Address of FacilityMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any learning to increase cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine physician and s the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📉 Vo Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9☐Unknown Part II. Other significant conditions contributing to geath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1□ Yes 2. No certificate l 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 NO 1 Yes 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending Injury death. investigation 1 □ Yes 2 □ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and certifier 29d. Date signed (Month, Day, Year) 19 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

EDDIE NAKHUDA, M.D.

MAY 21

31. Date filed (Month, Day, Year)

2008

HARDESTY

TIMONIUM, MD 21093

2300 DULANEY VALLEY ROAD

32. Registrar's Signature

SELLAN.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 4 AAS Doroth 2008 MA) /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE Riverview Kehabilitation Health Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Min Hours Months 1 ☐ M 2/2 F Director 218-26-2976 Jan. 24, 1930 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Itams 23a 909 Pine Road 21085 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item 1 □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph (unk) Spadaro Theresa Mary Hodizk ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bruce T. Haas / Son 909 Pine Road, Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Darlington Cemetery 5-19-08 Darlington, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundral Service bicem 22 Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final avadula Physician lea disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury Due to for as a consquence of Examiner K The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 20 No be detached 9 Unknown 9 Uriknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ on 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 52 certificate has ease 1 Yes 2 No 1 Yes 2 100 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) Be 20 No Hospital: Other: 4 Nursing Home 1 Tyes 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) completely filled in by the tuneral 27. Mann of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Diractor: After 1 atural 5 Pending investigation death. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide 24 hours a

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician:

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within 2 To the I

State Registrar

Medical

31. Date filed (Month, Day, Year)

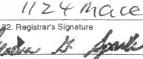
JOHL

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29b. Signature and title of certifier

30. Name and address

29a. Certifier



person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

we.

29d. Date signed (Month, Day, Year)

BOGO. MD 2/21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend trem 4a per doc 2879 5-21-08 vt.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Hall 3118 PM treda Ma 2008 /Medical 4c. County of Death 4a. Facility NATER TOWNS VIOLENCE ASSESTED Living 4b. City, Town, or Location of Death **Examiner** 4730 ATRIUM CT., #162 OWINGS MILLS BALTIMORE 7. Age (In yrs. last birthday) 84 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/10/1923 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 1□M 🎾 F 212-20-8801 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland htal Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show event, the Medical Exerciper trust be notified at 1 ☐ Yes 2 No Funeral Director MD BALTIMORE OWINGS MILLS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9 9413 GROFFS MILL ROAD 21117 **USA** 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 □Yes 2 No Specify: Completed by Specify: WHITE 3 ☐ Widowed 4 🏋 Divorced "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) MANAGER SOCIAL SECURITY ADMIN. 17. Father's Name (*First, Middle, Last)* ABRAHAM DISTILLER 18. Mother's Name (First, Middle, Maiden Surname) Be ROSE COOPER ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. SUSAN WARD/DAUGHTER 2039 RED RIVER RD. SYKESVILLE, MD 21784 20a. Method of Disposition
14 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State HEBREW YOUNG MEN CEM. 05/16/2008 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 21. Signature of Funeral Service Licensee Part 1. Enter the dis. ___, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disagraph Immediate Cause (Final Physician Failure 10 Throwe disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Alzherner's Sequentially list conditions, if any, leading to minimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence off To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Mam bosi Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 ☐+No 1 ☐ Yes 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Assisted いい 1∐Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 15/08 DOG53337 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Main Street Suite 200 Reisters teur, Md Seay 25 am. DOW 31. Date filed (Month, Day, Registrar's Signature 32. State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year John Johnson Jr. 5;55 May 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 525 Normandy Avenue n/a Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 X M 2 □ F 212-26-8296 2-21-1931 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1X Yes 2 No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5710 York Road, Apt. G2 21229 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No If Yes, Give Year or Dates 8.—52 . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ∐Yes 2 ∐XNo Specify: specify: African-American 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Helper Teamster 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Johnson Sr. Julia A. Lightfoot 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 525 Normandy Avenue, Baltimore, MD 21229 Michelle I. Johnson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-23-08 Garrison Forest Veterans Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wlie Funeral Home P.A. of Balto. Co. 9200 LibertyRoad, Randallstown, MD 21133 23a Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 Is marked other It any injury or other traumatic event, Ital Once.

Physician/Medical Examiner law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

the notified at

ral", or items 23a Examinar must b

Director

by Funeral

Completed

Be

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the burial-trans attending physician for use as the burial been signed by should be detact page 2 funeral director, this within 24 hours after death

To the Funeral Director.

completely filled in by the f

Certification: To Be Completed by

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Rosalyn

Juergens

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760,

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shock, or heart failure. List only o	ne cause on each line.	C	Onset and Death					
Immediate Cause (Final disease or condition	luna cancer	on	k year					
resulting in death)	Due to (o) as a consequence of):		1.00					
	patrone,							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin	Due to (or as a consequence of):							
Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):							
	. <u> </u>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	,	23d. Date of delivery Month Day Year					
Part II. Other significant conditions co	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
		1 Yes 2 No 3 Probab	oly 4 🗆 Unknow					
		4a. Was an autopsy performed? ☐ Yes 2 Moo 24b. Were autops prior to comp death? ☐ 1 ☐ Yes 2	oletion of cause of					
25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5	☐ Residence 6 ☐ Other (Specify)	aughter's Résidence					
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred						
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Lo. Cit	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	sician: To the best of my knowledge, death occurred at the time, date and place, and du ner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.							

29c. License number

1650 Orleans Street Johns Hopkins CRBI-693

D 60203

29d. Date signed (Month, Day, Year)

21, 2008

Baltimore Maryla

21231

State Registrar

10+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** hoon 4 arelo /Medical 4c. County of Death 4b. City, 4a. Facility Name (If not institution, give street and number) Examiner Hospice SEASONS BALTIMONE Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2√2 F 39 214-82-3643 Director 5-28-1968 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Modical Examinat must be notified at 1 ∑Yes 2 ☐ No Director Baltimore n/a MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with in the Health and Mental Hygiene. USA 21215 4718 Park Heights Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No If Yes, GiveX Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: African-American Ş 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than 'amy lajury or other fraumatic event, the Meonee. Elementary/Secondary (0-12) College (1-4or 5+) Health Care Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Johnson ဥ Leroy Johnson Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4718 Park Heights Avenue, Baltimore, MD 21215

of Disposition (Name of Date 20c. Location - City or Town, State James E. Bonner Jr./ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Crownsville Veterans Cem. 5-20-2008 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. uneral Service Licensee 9200 Liberty Road Randallstown, MD 21133 23a. Part Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ,Physician neunia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Hospital or Attending Physlcian: The law requires that the death certificate be exec Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) ed by the a 9 Unknown sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 € No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 19 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only Medical completely and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D

32. Registrar's Signature.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Mac Day Physician 00 JONES AUGUSTUS 2003 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GLEN ANNE ARUNDE HIGHWAY, APT. If Under 1 Year Months Days 9. Birthplace (State or **Funeral** Hours 216-29-8704 Usual Residence of Decedent Director 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Importment of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director OUNT 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) THGRADE 18. Mother's Name (First, Middle, Maiden Surname) [MN-CINKNOWN] 17. Father's Name (First, Middle, Last) Be HARLES ELIZABETH ဂ္ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERWOOD HOWARD BALTO, MD 21218 MATHUR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) BALTIMORE Funeral Service Licensee 21. Signature Sa 23a. P. rt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ck, or heart failure. List only one cause on each line. Im parate Cause (Final dis e or condition resulting in death) arcinoma **Physician** 5 Moult /Medical Due to (or as a consequence of): Examiner arcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transi one Due to (b) as a consequence of): attending physician for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2'XNo funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 714 136 5/16/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DALTITS. SAW HTEE 610 Crain Towers Tien Burnie Md 21061.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day; Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2008 05 19 6:30a. Jones Jr. Frank 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 4810 Cordelia Ave #15 Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) Months Days Hours Min. **X**□ M 2□ F 220-36-9928 02 06 40 MD Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County Baltimore 1X Yes 2 No NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21215 4810 Cordelia Ave #15 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12th grade College (1-4or 5+) Machine Operator W.R. Grace Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Rich Frank Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 Venus McNeil-Daughter 1630 Shady Side Rd, Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/23/08 Pikesville, Md Druid Ridge 4 Donation 5 ☐ Other (Specify) March F/H West 21. Signature of Funeral Service Licensee Mynei 4300 Wabash Ave, Baltimore, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER - IN com with disease or condition resulting in death) Due to (or as a consequance of): Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

be executed and burial-tran Box 68760, attending physician for use as the buria ed by the a detached f P.O. signed to Division of Vital Records, s been si should t page 2

Physician

/Medical

Examiner

Examiner funeral director, the

Physician

/Medical

Examiner

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Director

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Director

Funeral

Completed

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Department of Health and Mental Hygiens (2 incurs alier death with the Maryla Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating must be notified at once.

Pages 1 and 2 should be filed within 72 hours after of the filed within and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite

altimore, Maryland 21215-0036

with the Maryland

death

Physician/Medical \$ Completed Be Certification: To

Medical

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified filled in by

State Registrar

29b. Signature and title of tertifie

5 Pending investigation

6 Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Charles Or Gelto.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 2008 32 Registrar's Signature